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Focus Group Results: Family Health Pilot Test in Alexandria, Egypt

May 2000

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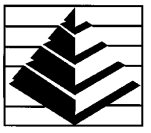

Partnerships
for Health
Reform
PHR

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Partnerships for Health Reform

PHR

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- better informed and more participatory policy processes in health sector reform;
- more equitable and sustainable health financing systems;
- improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and
- enhanced organization and management of health care systems and institutions to support specific health sector reforms.

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

Thirteen focus group sessions were conducted to examine a Family Health Care Pilot Project in one health district. The objectives of the pilot are to test reforms designed to improve quality, integrate services, and achieve universal coverage for a basic package of priority services. Participants provide feedback on quality of care and the start-up operations of the pilot, financing and contracting options, and service and payment preferences. Doctors, nurses, social workers and patients at public pilot sites and representatives of private practices and one non-governmental organization answer questions related to four themes: patient satisfaction with family health care; patient willingness and ability to pay for services; professional quality and management; provider willingness to contract with a new social insurance entity using performance-based incentives. The analysis of the results suggests areas for further investigation and recommendations for the improvement and expansion of the pilot test in Alexandria Governorate, Egypt.

Table of Contents

List of Tables

Acronyms

ECTAT	European Community Technical Assistance Team
FM	Family Medicine
FP	Family Planning
HIO	Health Insurance Organization
MOHP	Ministry of Health and Population
NGO	Non-governmental Organization
PHR	Partnerships for Health Reform (USAID)
TSO	Technical Support Office (MOHP Cairo)
TST	Technical Support Team (MOHP Alexandria)
USAID	United States Agency for International Development

Acknowledgments

The Arab Republic of Egypt's health reform initiatives, including the integrated primary and preventive care pilot test described in this document, are led by H.E. Ismail Sallam, M.D., Minister of Health, and managed by the directors and staff of the Ministry of Health and Population (MOHP). Dr. Wagida Anwar, Director of the MOHP Technical Support Office (TSO), leads the team responsible for the management of the pilot test and coordinates donor funding and technical assistance to the pilot project.

The Partnerships for Health Reform (PHR) Egypt technical staff members contributed in preparing the topics and briefing the moderators on the subject matter to be covered which was critical to obtaining useful and meaningful results: Mary Paterson, Ahsan Sadiq, Hassan Salah, Randa El Turk, and Gary Gaumer (Abt consultant). Nancy Samy coordinated logistics and translation work. Julien Denakpo, PHR operations manager and Suzanne Khalil, PHR program assistant in Alexandria, also assisted with logistics. Special mention must be made of PHR Alexandria driver Abuda who was willing to drive us through muddy unpaved roads and over long distances in inclement weather to find and invite focus group participants.

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Special thanks are due the MOHP's Alexandria Technical Support Team (TST) headed by Dr. Mahdeya Ali, and to Dr. Mostafa Shaheen and Mohammed Abu Said for their help in identifying and recruiting the respondents and to the Health Insurance Organization (HIO) Family Health Advisory Council/Stanley Branch/Alexandria.

Fawzeya Tadros headed the team who translated the Arabic manuscripts from all the sessions to English. Nancy Samy assisted with the review of the translations.

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Deepest thanks go to the health workers and patients of the Montazah District pilot who contributed generously of their time, energy, and effort to candidly participate in the focus groups: Director, staff, and patients of Seuf MOHP Family Health Center; directors and staff of Mohsen, Khorshed, Gon MOHP Family Health Units; director and staff of HIO Abu Qir Family Health Center; and the patients of MOHP and HIO non-pilot health units at Montazah and Seuf, respectively.

The excellence and professionalism of the moderators who co-author this report were critical factors in the cooperation of the respondents and the usefulness of the research.

Executive Summary

Background

In May 1999, Seuf Family Health Center opened its doors in Montazah Health District, Alexandria Governorate, Egypt. Seuf was the first of five public clinics to start operation in a pilot project to test and demonstrate comprehensive primary care reforms envisaged by the Egyptian government and the Ministry of Health and Population (MOHP) and supported with technical assistance through the Partnerships for Health Reform (PHR) by the United States Agency for International Development (USAID). (A description of all the elements of the piloted reforms is in the box.) A technical assistance team from the European Community (ECTAT) and financing from the World Bank will continue and expand the pilot in Alexandria and two or more other governorates, with a view to its eventual replication throughout the country.

The first phase of the pilot was to adapt to the Egyptian context a model of health care based on the practice of Family Medicine. Once the new care model was in place, the second phase was to test a new social insurance fund and financing for the new service delivery model contingent on facility accreditation and performance-based management. The goals of the primary care reform are to achieve universal coverage with a basic package of benefits and to improve the quality of services, thereby inducing higher utilization of primary and preventive care services.

Purpose of the Focus Groups

In order to set a baseline and monitor progress on the pilot test at five sites, receive rapid feedback, and explore options to pending policy decisions and related communications and marketing strategies for the launch of the Family Health Fund, PHR sponsored a series of focus groups with pilot participants and stakeholders in the pilot district. PHR grouped questions under four themes:

1. Patient satisfaction with family health care
2. Patient willingness and ability to pay for family health care and insurance
3. Professional quality in family health services and management
4. Provider willingness to contract with the Family Health Fund

Methodology

Planning and preparations for the focus groups began in November 1999. The moderators led a one-day training for the assistant note takers/observers at the start of January 2000 and the sessions were held in January and February 2000. Analysis of the results was done in March and debriefings on the results with sponsors and stakeholders were held in April and May 2000.

PHR, with input from the MOHP Technical Support Office (TSO) and Technical Support Team (TST), selected two experienced, independent moderators from local universities, a physician and nurse, male and female, who were familiar with the pilot health district.

Thirteen two-hour sessions, with an average of eight participants each, were held at a neutral and convenient location for the providers; sessions with patients were held in the clinics' health education rooms.

Provider participants were selected randomly from among the five participating pilot clinics; as a control, patients from one MOHP and one HIO non-pilot health unit were also included. Three NGO and three private for-profit providers operating independently within or near the pilot health district were selected for the sessions on private provider willingness to contract with the Fund. (However, only one NGO representative participated).

PHR, with the moderators, conducted four separate final debriefings with discussions of suggested next steps to key stakeholder groups in the pilot: MOHP TSO for the reform, the MOHP TST for the reform in the Alexandria pilot area, ECTAT and PHR technical staff, and USAID/Cairo's Population, Health and Nutrition staff.

Key Findings

Service and Satisfaction

Separate sessions with providers and with patients using pilot facilities confirm high satisfaction with the Family Medicine approach for the following reasons:

- Providers expressed professional satisfaction with the efficiency of the holistic approach and improved relations with patients.
- Patients expressed satisfaction with the convenience of integrated services delivered at one site that cover the needs of the whole family, saving time and transportation costs.
- Patients perceived the quality of care as good and summed up by one respondent as "comfort, care, cleanliness."
- Patients also recognized the importance of the continuity of care and the benefits of seeing the same doctor/nurse team, of having a "family file" (medical records on each family member). Patients exhibited satisfaction and trust by indicating that they routinely request their assigned doctor/nurse team on repeat visits.
- Some patients indicated their preference not to be referred to specialists. (This is partly due to trust in the family doctor but also to the added expense of traveling to another site and paying additional fees at referral sites.) Patients and family doctors both expressed their preference to have specialists on site or have specialists rotating on designated days and times among all the units.
- All patients highly value close access to the health facility and want emergency services at all sites.
- Patients in clinics where no appointment system existed would like one to reduce waiting

times (particularly for those coming from afar, who will not return home to wait).

Payment

- *Providers* indicated that if fees were to be raised it should be done at the start-up of a clinic and not after operations at lower fees had begun. (Some believed this accounts for pilot patients' reluctance to pay more for better quality services at the pilot sites). Providers also believed it was important to raise drug fees to deter patients from hoarding prescription drugs or abusing them. However, all providers and patients believed there had to be a subsidy for those unable to pay.

- *Salaried patients* preferred deductions and *non-salaried* preferred payments per visit.

- Despite willingness to pay private providers, there was negativity about prepayment and a rostering fee. *Patients and social workers* believed that it either would lead to over-use of facilities, on the one hand, or a high drop-out rate, on the other.

- *Patients and providers* believed that charges at public facilities should be lower than at private clinics. Patients did agree that they had to pay more for referral to specialists and for tests.

- *Some patients* indicated their willingness to pay for services at a location close to home, for shorter waiting time, and for access to drugs.

- Contrary to pilot patients, *non-pilot patients* who were low income and from peri-urban and rural areas were more willing to pay for family health services, as they have high out-of-pocket expenses for drugs and visits to private doctors when the public system is not accessible or cannot meet their needs.

Referral System

At start-up of the pilot sites an established referral system had not yet been developed as reflected in the following responses from *providers*:

- Patients prefer close referral sites (in the Egyptian context, transportation, traffic, travel across distances is cumbersome.

- Record sharing between the family health center or unit and other referral sites needed to be established to ensure continuity of care. Hospitals and other referral sites, including vertical programs, had no incentives for cooperation with the family health facilities.

- Related to the point above, fees needed to be aligned across the sites. Some vertical programs provided services at no charge; hospitals charged fees beyond the ability of the users to pay.

- Once in place, information needed to be provided clearly and systematically to patients explaining the referral system, procedure, fees, and rationale. (This would avoid patients dropping out and also allay fears of referral to unknown providers and sites.)

Professional Quality

- *Family doctors and nurses* had received training in the principles of Family Medicine, working in teams, but as many were originally trained as general practitioners or in a specialty they expressed a strong desire to have clinical hands-on training in areas such as family planning and reproductive health, cardiology, and emergency medicine. Nurses wanted more training on equipment.

- *Providers* also expressed frustration with existing MOHP prescribing policies as too stringent on the chronically ill or the elderly, who often required more than the two prescriptions allowed.

- Medical records and statistics elicited many comments from *providers*. The family file records needed to be expanded to include special forms for reproductive age females, children, and emergencies. Providers complained of the burden of meeting all record-keeping requirements. They suggested consolidating data collection and forms and to standardize the system to allow intergovernorate sharing on cross-border patients.

Management

- *Clinic directors and providers* at the pilot sites indicated the need to institutionalize their operation by establishment of a Family Medicine "authority" in the MOHP system. This authority could facilitate operational management issues like personnel, supplies and equipment, maintenance, transportation, health education resources, and others, and troubleshoot problems. Without an institutional home, the family health clinics were caught in a bureaucratic void.

- *Providers* felt that it is not feasible for the site directors to also carry a patient roster.

- There is a critical shortage of trained family doctors and nurses in the system and as a result no relief personnel. (Training and recruitment is ongoing but it will be some time before deployment can begin.)

Contracting

Public, private for-profit, and NGO provider responses converge on the following points regarding contracting with the proposed Family Health Fund:

- Specialists should be included in the contract. (This would deter opposition/win cooperation from specialists; private multi-specialty practices could participate; patients do not like outside referrals.)

- MOHP or the Family Health Fund should provide training and orientation materials on the family health system, procedures, and policies.

- MOHP facilities should always charge less than private ones.

- There needs to be a mechanism in place to prevent patient double-rostering.

- Patient choice of provider should be an option. The MOHP or Family Health Fund should

do the marketing and raise patient awareness of the new system.

- MOHP should promote Family Medicine to the professions to advance and enhance recognition of the discipline (including licensing).

- *Public and private providers* want per capita incentives for seeing patients over and above an agreed upon number and a fixed monthly base salary. Most would agree to the proposed performance-based measures (such as coverage of priority services on their rosters, waiting time, average number of referrals and prescriptions, and patient satisfaction).

- *Private providers* suggested that drugs be included or subsidized as an added attraction to patients.

Awareness, Information, and Outreach

- Public and private physicians noted that the concept of Family Medicine/family health care is new to the country and must be promoted.

- Health education and promotion efforts need to be expanded and coordinated with vertical programs. Prevention is an important component of a family health approach. Nurses and social workers indicated it was difficult to get materials for distribution at the family health sites.

- Providers and social workers suggested adding the words “care” or “services” to design of the Family Health Fund logo or seal of approval.

Implications for the Replication of the Pilot and Recommendations: Policy, Operations, and Promotion

The pilot process is not static, yet the focus groups results are specific to a given point in that process. Some problems have been rectified, progress has been made on certain issues, and others require more investigation. Regardless of the status of each issue, the discussion below signals areas that are important for either starting up new demonstration test sites or for consolidating reforms in existing sites.

Policy

Pilot Management Authority: Management and administration at the central, governorate, and district levels has to have the authority, flexibility, and means to respond to the demands of the new model for supplies and equipment, drugs, training, personnel, pharmaceuticals, transportation, telephone and information system and computer support issues, among others. A ministerial order (suggested by a participant) could facilitate operation of the pilot and obtain for it the necessary cooperation from the existing system.

Accreditation: Lack of regulatory authority to accompany accreditation will likely dilute the impact accreditation adds to the new model as a requirement for contracting and quality improvement. The accreditation system can be established and promoted, provided a budget to meet accreditation

requirements is provided to the public pilot clinics. Private clinics also inquired as to whether they would receive support to meet accreditation requirements.

Financing: If more pilot sites begin operation prior to when contracting and insurance mechanisms are in place, a provisional plan to compensate pilot personnel could prevent disruption; late or irregular payment of incentives loses credibility for the reform and can make it hard to retain and attract the best people who are critical for its success.

A clear subsidy policy and test mechanism to protect the poorest is clearly of concern to providers and patients as well as policymakers, if user fees are to be substantially raised or roster fees introduced. More testing at sites could provide insight to policymakers on patients' willingness to pay for services at public facilities and the methods of payment. There seems to be consensus among providers that if fees are to be raised, it should be done at start-up of the site.

Service Integration: The integrated, comprehensive care model intrinsic to the primary care reform warrants a plan to transition the role of the vertical programs and to make use of their specialized expertise in the new system. A multi-donor/MOHP/HIO effort needs to plan for a smooth transition.

Providers and patients indicated their strong preference for close access to specialists for a variety of reasons. Multi-specialty family practice models or regularly scheduled visiting specialists could be tested for their financial feasibility in the pilot.

Pharmaceutical: MOHP, HIO, and private providers use different systems for procurement, pricing, record keeping, stocking, and prescribing, which need rationalizing in the context of the pilot, as well as the longer-term sector reform.

Intergovernorate: Until the pilot is expanded to more sites and the new national information system is designed and operational, an interim plan for addressing intergovernorate patient issues could be developed to provide guidance to sites "caught in the middle."

Contracting: Objective performance measures, timely payment of incentives, patient marketing, inclusion of specialists, and government commitment to the family health model are the factors most likely to recruit public and private providers to participate in the pilot.

Emergency: A clear emergency services policy needs to be outlined and training needs to be provided for pilot facility staff.

Operations

Referrals and Information Systems: The two biggest challenges related to operations of the pilot sites revolve around the establishment of a workable referral system and the development and use of the computer-based information system. The continuity of care that the family health approach seeks to achieve necessitates a referral process that is workable and clearly understood by both providers and patients. The MOHP is currently examining possible solutions to the referral dilemma and an interim pilot referral system is needed until referral and related financing policies are determined.

The burden of record keeping, the design of the clinic-based information system, and adequate training and support for the computer system is a priority for the smooth start-up of more pilot sites. Contracting cannot rely on clinic data until this system is corrected and tested. The MOHP is examining how to standardize the information systems.

Training: The HIO medical staff had received no training in family practice and ought to be included in the MOHP-sponsored training if HIO will participate in the pilot and continue to deliver primary care services to the insured under the reform program. All providers at MOHP sites asked for practical training in key areas they are expected to treat at the primary level, most notably family planning and reproductive health. Practical, on-site training at existing and new sites in these priority services should be arranged as soon as possible. Experts from vertical programs could be seconded to pilot sites for short periods, for example.

Promotion

Marketing Family Health, Quality, Insurance: The MOHP may want to consider a campaign to promote the concept of family health as part of expanded health education and promotion activities. Such a campaign could serve to pave the way for an eventual enrollment campaign for the Family Health Fund and address the need to raise public awareness and promote Family Medicine to the professions in the health sector.

Providers and patients did not like the use of the word "Fund" in the proposed logo for the Family Health Fund. A question of strategy arises as to whether a logo should be rolled out with the new facility accreditation system, or in the context of the Family Health Fund (with a modified name) launch as a corporate logo. In either case, the logo could serve as a seal of approval of facilities, health promotional material, and other uses. This question is also relevant to the newly announced Association for Family Practice (provisional name) and its role in promoting the profession and setting standards for family physicians and nurses.

Consensus Building: To varying degrees, reluctance or even distrust of contracting with government needs to be overcome by MOHP public relations efforts. The MOHP and HIO should jointly convene consultative and consensus-building briefings with private providers and NGOs in the pilot governorate(s) and also use in-depth interviews, focus groups, or surveys to engage their participation and receive their feedback on proposed policies.

Stakeholder Feedback: In addition to periodic monitoring and to explore policy issues, more focus groups could be held to receive feedback from political and community representatives in the pilot district and sections of the MOHP whose support will be important for the expansion of the pilot. Finally, focus groups or in-depth interviews can be used to either validate or clarify findings of more formal monitoring and evaluation methods and statistics. The MOHP capacity to use qualitative research for stakeholder feedback and participation and to contract local support for these activities can be strengthened.

Organization of the Report

The body of this report provides more detailed information on the topics covered or raised in the focus groups and describes responses on the diverse topics according to each type of respondent group. Conclusions and suggestions for follow-up are grouped according to policy, operations, and pilot communications. The annexes contain the English translation of the topic guides used by the moderators and matrices developed to summarize results. An index of the results according to topic is also included. Transcribed manuscripts of the sessions are available on request and have been provided to the TSO.

1. Background of the Family Health Care Pilot Project

In May 1999, Seuf Family Health Center opened its doors in Montaza Health District, in a peri-urban area of Alexandria Governorate, Egypt. Seuf was the first of five public clinics slated to start operation in a pilot project to test and demonstrate comprehensive primary care reforms envisaged by the Egyptian government and the Ministry of Health and Population (MOHP), supported with technical assistance through the United States Agency for International Development (USAID)-funded Partnerships for Health Reform (PHR) Project. (A description of all the elements of the piloted reforms is in Box 1 and Table 1 gives a quick profile of the pilot sites.) A technical assistance team from the European Community (ECTAT) and financing from the World Bank are to continue and expand the pilot in Alexandria and two or more other governorates, with a view to its eventual replication throughout the country.

The first phase of the pilot was to adapt, as appropriate to the Egyptian context, a model of integrated health care based on the practice of Family Medicine. Once the new care model was in place, the second phase was to test a new social insurance fund to finance the new service delivery model contingent on facility accreditation and performance-based contracts.

The goals of the primary care reform are to improve quality of care and achieve universal coverage through a basic benefits package of primary care services. The integrated care model was chosen to improve sustainability in a health system fragmented by a plethora of donor-supported vertical programs which in large part have been successful but are not sustainable. Over time, the vertical programs would transition to new roles in the system such as assuring quality, conducting training or operations research, or providing specialized consultation based on referral from the family health providers.

The health sector reform strategy of the Egyptian MOHP begins with strengthening of the primary care system to improve preventive as well as curative care and potentially reduce reliance on the more costly specialists and tertiary care facilities. The strategy also calls for private and non-governmental organization (NGO) providers to contract with the new social insurance fund, called the Family Health Fund, so to extend coverage and offer more consumer choice among accredited facilities.

Concurrent with the introduction of the health care model, systems to collect data for monitoring and evaluation were also in development. However there were several factors pushing for start-up of the service delivery component although the computer-based information systems and training were not fully in place. First, there was a need to start testing the care model to allow work on the policies to finance it to advance and to demonstrate the reform to those who were expected to implement it. Second, there was also pressure to show activity and results on the reform program to win political support. Third, PHR's three-year contract with USAID in Egypt, begun in late 1997, meant there were barely two years to design, implement, assess, and establish the pilot before follow-on teams from the ECTAT and World Bank would have to take over support to the MOHP in 2000.

To address the need for some baseline monitoring information without compromising the speed of implementation, focus groups were conducted. The focus groups allowed PHR planners and technical advisors to monitor progress, identify unanticipated problems, and get feedback from patients and providers who were living the reform and who represented the intended beneficiaries.

Box 1. The Family Health Care Pilot Test for Primary Care Reform

In 1997, the Ministry of Health and Population of Egypt adopted a new strategy to reform the health system in phases over a period of 15-20 years. The first phase of the strategy seeks to provide *all* Egyptians with access to better quality primary care and preventive services. A basic package of priority services will be financed through a single social insurance entity, the Family Health Fund, combining public funds and user co-payments according to ability to pay.

The World Bank, the European Union, and USAID support this MOHP initiative with funding and technical assistance. PHR's role is to assist with policy design and implementation and the start-up of a pilot project that tests how best to turn the new primary care strategy into reality. This new strategy aims to use scarce resources efficiently and benefit people who are most in need: the underserved population, the poor, and those at high risk, particularly women and children.

A New Care Model to Sustain Health Gains

In the past, Egypt has made significant progress in many aspects of primary care. Its programs for childhood immunization, schistosomiasis control, family planning, and diarrheal disease control have yielded positive results. Despite their success, these programs have fragmented the delivery system into many specialized, vertical programs. The MOHP is committed to building an integrated service delivery system for primary care and preventive services centered on the Family Medicine approach.

Priorities for Primary Care Reform

The objectives of the MOHP's new primary care strategy are to:

- Improve quality of care and increase community health awareness and patient satisfaction
- Increase access to care for underserved communities and areas of the country
- Combine public and private expenditures on health to provide, at minimum, a basic package of services and essential drugs to all Egyptians, reducing the burden of out-of-pocket expenditures on lower-income families
- Integrate the provision of services around individuals and families, restructuring today's fragmented facilities and financing into a system of community-focused family health providers so to consolidate health gains, increase efficiency without sacrificing quality, and ensure sustainability of services
- Create a more effective public–private partnership in the provision of health services by contracting private providers and NGOs to deliver priority health services and allowing patient choice of provider

Effective primary and preventive care is the first line of defense against chronic or debilitating illness and loss of productivity. It reduces the need for expensive curative and hospital care and results in savings of scarce resources for all.

Pilot Project: Learning by Doing

The purpose of the pilot project is to test policy options and operational models for the three main components of a comprehensive, integrated primary care system. All three components are inter-related and necessary for a successful reform. The pilot project is developing, monitoring, and refining:

Service delivery: integrated delivery of priority services and a Family Medicine approach to a roster of roughly 600 families or 2500 people using a family physician/nurse practice model.

Financing: Family Health Fund covering the Basic Benefits Package (based on public funds and beneficiary co-payments according to ability to pay); contracting public and private providers and services to ensure quality and efficiency

Regulation: Quality improvement through clinical guidelines, training, and accreditation of facilities; facility computer-based information systems for planning and monitoring quality measures, health outcomes, and resources

Focus groups and in-depth interviews with providers, patients, and representatives of the government and private sectors supplement statistical analysis to give planners insight on what works, what doesn't, and why. Diverse communications activities raise the awareness and participation of all stakeholders in the reform, build consensus, and facilitate replication of the results.

Timeline: Start, Learn, and Expand

Planning and preparations for the pilot test began in 1998 in Alexandria Governorate's Montazah District. In May 1999, the first pilot site at Seuf started receiving patients. Three more MOHP units began operation over the course of 1999 and a center managed by the Health Insurance Organization (HIO) began operation in early 2000. In total there are be two family health centers (one MOHP and one HIO) and 3 MOHP family health units. An NGO and a private group practice were to be contracted in 2000 as well, bringing the total pilot facility number to seven.

Results from the pilot sites will be used to refine and roll out the new model to the whole of Alexandria Governorate and to Menoufia and Sohag Governorates—where the reforms can be tested in different settings. The primary care reform is slated to cover at least three pilot governorates over the course of a five-year period culminating in 2005.

Concurrent to the operation of the initial pilot test sites, a technical assistance team funded by the World Bank is developing a *master plan* to map out facility infrastructure and human resource requirements for the new system.

Expected Results: Features of the New System

- All public primary care facilities up to the district level consolidated and rehabilitated into family health units, family health centers, and district hospitals.
- Physicians, nurses, and other health professionals trained in Family Medicine.
- Quality standards developed to accredit any public and private physician practices and facilities contracted to provide services contained in the basic benefits package.
- National Family Health Fund (social insurance) established. The fund receives monies from various sources (Ministry of Finance, MOHP, HIO, and equitable user co-payments) and purchases services from accredited providers.
- Families have the right to choose their family physician; that is, "the money follows the beneficiary." Beneficiary satisfaction motivates sustained quality improvements.
- Computer-based systems exist for registering and referring beneficiaries and tracking their care, for registering providers, for provider billing and payment, and for monitoring and evaluation of health outcomes and resource use.
- Contracting incentives used to balance efficiency and quality; to induce providers to receive low-income patients or to work in under-served areas.
- There is greater community participation in how services are organized and provided as patient satisfaction is systematically monitored, patient choice of provider instituted during open enrollment periods annually, community representatives participate in facility oversight meetings, and community outreach efforts are expanded.
- Complementary to integration of care, there is expanded and broad-based public health education on priority issues and new lifestyle-related health risks.

Table 1. Profile on Alexandria Governorate Pilot Sites

Name	Date Opened	Number Famliy Doctor/Nurse Team	Number of Specialists	Number of Social Workers	Number of Pharmacists
Seuf MOHP Family Health Center (developing periphery of Montazah District)	May 1999	10	4	3	2
Khorshed MOHP Family Health Unit (rural facility)	Sept. 1999	7	0	2	2
Mohsen MOHP Family Health Unit (near Seuf)	Sept. 1999	6	0	2	2
Gon MOHP Family Health Unit (rural facility)	Sept. 1999	6	0	2	1
Abu Qir HIO Family Health Center (mixed residential and commercial, rural, fishing district)	Feb. 2000	10	6	3	2

***Notes*:** All facilities were new or renovated but were constructed prior to the MOHP Master Plan for the renovation and construction of reform facilities that has been developed with assistance from the World Bank and a team from Denmark.

Each family doctor/nurse team is assigned a roster of 600 families with an average of five members per family.

2. Purpose and Organization of the Focus Groups

Given limitations on resources, the small scale and newness of the pilot, and the importance of patient participation, qualitative research in the form of the focus groups would best allow the MOHP technical team and advisors to get feedback in the needed timeframe. Focus group results would indicate where to make quick adjustments to ongoing and planned pilot start-ups, reveal previously undocumented policy issues, guide communications efforts by pinpointing areas of concern or confusion, and suggest any broader policy studies or surveys needed for the roll-out of the pilot on a larger scale. The focus groups also would provide a baseline for monitoring pilot operations and provide insight into attitudes, opinions, and preferences of providers and consumers at the center of the reform.

Focus groups provide "snapshots" of the pilot *at a given point in time*. It is important to remember that the pilot process is a dynamic one that changes daily. Major or minor advances as well as setbacks can occur overnight. Therefore, until there is a series of such snapshots captured over time, the reader of this report will not have a full and accurate picture of the whole pilot and the process in terms of potential for its replication and sustainability, pitfalls, and impact.

There are limits to focus group research. The results cannot be generalized due to the small samples, and they require validation by a combination of other qualitative research (in-depth interviews and more focus groups) and quantitative research such as surveys or secondary analysis of other data. Results are not, and should not be, quantified. They are sought for insight.

2.1 Topics

The discussion topics that were chosen focused on the most pressing priorities for advancing the young project at that stage in time. It was also important to investigate patient satisfaction for the success of the experiment.

PHR grouped questions into four topic areas:

1. Patient satisfaction with family health care
2. Patient willingness and ability to pay for family health care and insurance
3. Professional quality in family health services and management
4. Provider willingness to contract with the Family Health Fund

These four topics would provide policymakers, technical advisors, and managers information for:

- Pilot monitoring of policy implementation and operations
- Policy planning for extending social insurance and improving performance through the Family Health Fund

> A positioning strategy for marketing family health care and the insurance to providers and to consumers

2.2 Participant Selection

The moderators randomly selected provider participants using the employee lists from each pilot facility. Social workers helped recruit participants for the sessions with patients at Seuf Family Health Center, the site that had been in operation the longest. As a control, patients from one MOHP and one HIO non-pilot health unit were also included. With assistance from the Technical Support Office (TSO) and Technical Support Team (TST), three NGO and three private for-profit providers operating independently within or near the pilot health district were selected for the sessions on private provider willingness to contract with the Fund. (However, only one NGO representative participated.) See Table 2 for the breakdown of sessions, topics, and participant type.

The respondents were doctors who in the majority had received special training abroad in family practice at Exeter and East Anglia universities in the U.K. and University of California/Irvine. Nurses included some High Institute graduates (four-year program) who trained abroad with the doctors, as well as nurses with two years of technical training. Social workers were important to include because they receive all complaints and are responsible for exempting patients from fees through an informal, subjective system they used to profile patients and investigate their means on a case by case basis.

As a point of comparison with pilot patient responses, patients at two non-participating MOHP and HIO clinics were included. Pilot patients were divided into male and female groups. Males selected had HIO insurance as salaried workers and women were uninsured. (In many pilot families, insured males would go to non-pilot HIO sites and their uninsured wives and children would go to pilot sites.) Staff from the one HIO pilot facility was also included but their site had barely begun operation at the time of the focus groups and they had not received prior family practice training.

Table 2. Time Table for Focus Groups, revised 1/25/00

Date	Session Number	Group Type	Topic	Participants	Venue	Number of Persons	Two Assists per Session	Time
Jan. 26, 2000	7	Patient	1. Satisfactation 2. Willingness to Pay	Pilot: Non-insured females	Seuf Unit	8 from Seuf only	Wessam Amr	9 – 11
Jan. 26, 2000	6	Patient	1. Satisfaction 2. Willingness to Pay	Pilot: Insured Males	Seuf Unit	8 from Seuf only	Wessam Amr	4 – 6
Jan. 27, 2000	1	Provider	4. Willingness to Contract	Physicians 5 pilot sites	Sheraton	10 (2 per clinic)	Wessam Amr	10 – 12
Jan. 27, 2000	2	Provider	4. Willingness to Contract	Nurses 5 pilot sites	Sheraton	10 (2 per clinic)	Wessam Amr	1 – 3
Jan. 30, 2000	3	Provider	3. Professional Quality	Pharmacists 5 pilot sites	Sheraton	7 (2/center; 1/unit)	Nancy, Amr	10 – 12
Jan. 30, 2000	5	Provider	1. Patient Satisfaction 2. Willing to Pay	Social Workers 5 pilot sites	Sheraton	7	Nancy Amr	1 – 3
Jan. 31, 2000	9	Patient	1. Patient Satisfaction 2. Willingness to Pay	Non-pilot: Females	MOHP Montazah	8 from MOHP only	Amr Nancy	10 – 12
Jan. 31, 2000	11	Provider	3. Professional Quality	Directors 5 pilot sites	Sheraton	5	Amr Nancy	1 – 3
Feb. 1, 2000	12	Provider	3. Professional Quality	Physicians Seuf pilot site only	Sheraton	6 from Seuf only	Marwa Wessam	10 – 12
Feb. 1, 2000	13	Provider	3. Professional Quality	Nurses and social workers: Seuf pilot site	Sheraton	8 from Seuf only	Marwa Wessam	1 – 3
Feb. 3, 2000	4	Provider	4. Willingness to Contract 2. Willingness to pay	Physicians (private directors/physicians from 3 practices)	Sheraton	6 from 3 practices (2 multi-specialty)	Marwa Wessam	10 – 12
Feb. 3, 2000	10	Provider	4. Willingness to contract 2. Willingness to pay	NGOs (Directors/Physicians from three groups)	Sheraton	2 from one NGO	Marwa Wessam	1 – 3
Feb. 7, 2000	8	Patient	1. Patient Satisfaction 2. Willingness to Pay	Non-pilot: Males	HIO/Seuf	8 from HIO only	Marwa	10 – 12

2.3 Methodology

Planning and preparations for the focus groups began in November 1999. The moderators led a one-day training for the assistant note takers/observers at the start of January (see Annex A for instructions) and the sessions were held in January and February 2000. Analysis of the results was done in March and debriefings on the results with sponsors and stakeholders were held in April and May 2000. (See Annex B for a matrix that summarizes results, Annex C for result topics by theme session.)

PHR, with input from the TSO and TST, selected two experienced, independent moderators from local universities, a physician and nurse, male and female, who were familiar with the pilot health district.

Thirteen two-hour sessions (some sessions with providers extended to three at the request of the respondents who were eager to use the focus group vehicle for feedback to their superiors), with an average of eight participants each, were held at a neutral and comfortable location for the providers (hotel meeting room near to their workplace). Sessions with patients were held in the clinics' health education rooms.

PHR's technical team prepared topic areas and briefed moderators on issues and questions. The moderators then prepared topic guides in Arabic (see translations in Annex D) and conducted all sessions in Arabic. Due to the familiarity of target participants with the reform's technical advisors from the MOHP and PHR, and due to the language barrier, sponsor observers were limited to one anonymous MOHP/TSO member at two provider sessions and to the note taker/observers assisting the moderators who were bilingual research and program assistants from PHR's technical team.

Sessions were scheduled in close succession to reduce the possibility of participants sharing questions and responses with co-workers and to use sessions with different types of respondents to cross-validate responses on common topics. Due to the small number of potential participants, with the exception of patients, holding a second session per topic with the same type of respondents to compare to the first was not warranted.

All sessions were taped with the permission of the respondents, transcribed, and translated into English. Note taker/observers provided notes and assisted moderators with the preliminary analysis.

PHR did further analysis and presented, along with the moderators, four separate final debriefings with discussions of suggested next steps to key stakeholder groups in the pilot: the MOHP TSO for the reform, the MOHP TST for the reform in the Alexandria pilot area, the ECTAT and PHR technical staff, and USAID Cairo's Population, Health and Nutrition staff.

The need to prepare and conduct sessions in Arabic limited PHR's ability to monitor the sessions. Ideally, PHR and MOHP technical sponsors would have been able to listen to sessions through earphones and suggest follow-up questions or modify lines of questioning for moderators through the course of each session, assuming audiophone equipment often used by conference interpreters is available and affordable at a site appropriate for the sessions. (Session rooms with two-way mirrors are sometimes available in capital cities where large commercial advertising and research agencies operate.)

One factor to consider in the analysis concerns the variability among the pilot sites. Seuf Family Health Center was the first to open in May 1999 and serves as the demonstration site. The four MOHP pilot health units had only been in operation for half the time (October 1999) that Seuf had at the time of the focus groups and did not have the direct intervention of PHR technical assistance that Seuf had; as

units, and not centers, they did not have the ob/gyn, pediatric, or internist specialists that were on site at Seuf. Technical assistance support to the MOHP health units was the main responsibility of the MOHP/TSO in consultation with PHR as needed. Therefore, responses to some questions and some issues raised vary across Seuf Family Health Center and the units.

2.4 Capacity-building: Using Focus Groups to Encourage Stakeholder Participation in the Reform Process and Inform Strategic Management

The first round of focus group sessions and the richness of the results they produced provided a useful demonstration of this qualitative research as a flexible and cost-effective tool to aid in the strategic management of the reform process. Focus group research served to tap and channel the feedback of stakeholders into policy planning, management, and monitoring as well as serving its more traditional use for planning and monitoring marketing and communications strategies. While the TSO, the principal MOHP counterpart to PHR, did not have previous experience in conducting focus groups and could not assign counterparts to participate at every stage of the focus group work, as was PHR's original intention, through its demonstration, they did perceive its usefulness to inform their work. The Family Planning and Reproductive Health groups in the MOHP had used focus groups and other qualitative research for social marketing, but it had not been used for the sector reform process or by members of the reform team. Any lingering skepticism about the utility of encouraging stakeholder feedback through this or any other means was overcome by the debriefings and evidenced by some TSO team members' eagerness to read the Arabic transcription of the sessions in full.

A worthwhile capacity-building follow-up activity would be training TSO and TST members in how to use, plan, and organize focus groups. However, it is recommended that, due to their vested interests and management authority in the reform program, they contract independent, trained focus group moderators to conduct the sessions. Focus groups could also be used to query MOHP managers and staff of vertical programs, political stakeholders, and community representatives, among others in the pilot district.

3. Findings: Patient Perspectives on Service Delivery Reforms

3.1 Satisfaction with New Family Health Services (Seuf and one MOHP non-pilot unit and one HIO non-pilot unit)

> Pilot patients prefer to see the same doctor/nurse team, recognize the value of the family record, and the comprehensive, quality care (Seuf)

"We get used to them and feel comfortable with them. They are always familiar with our case."

"Everything is in the file and the physician can know what I took before."

"It's much better like this because they open my file and don't ask me the same questions all over again."

"The physician takes time to examine thoroughly and carefully to the extent that the next patient waiting outside gets anxious".

"The sheets and towels are as those seen in a bride's room, and the couch is clean."

"There are enough comfortable chairs, the area is clean and the fans are working, lights are on and everything is very, very nice."

"There is comfort, cleanliness, and care."

"Even the nurses are nice and treat us with respect."

> Regarding feelings of security and privacy, one patient asserted:

"*I have this feeling with the physician only and sometimes also with the social worker."*

> Patients highly value close access to the clinic.

"The prices are suitable and I do not have to pay for transportation."

"According to my pace, it takes me an hour, almost an hour. I cannot walk fast."

"I used to go to the government hospital and to the university hospital and take transportation, so now it's so much easier for us[to get here]."

"It saves time because it's so close to us."

"The unit where we used to go was far from us. Thank God we have now this center."

"We come here only because it is near to where we live and it doesn't differ much from the polyclinics".

> Patients prefer centers where there are specialists and emergency services. They do not like referrals to other places due to the time and transportation costs as well as higher fees and treatment by strangers.

"*Emergency doctors are not committed. Sometimes we come and do not find any physician in the emergency section."*

"I have to take a taxi to reach here. So I cannot come here and then be sent somewhere else."

"What is the use of having a center nearby? They should serve me well and not send me elsewhere."

"I have insurance but I would like emergency services to be available near me. I have a heart problem. When I have chest pain I have to take a taxi to the hospital but the center is closer to me."

"When my wife was in labor they said she had to be referred to a hospital. They called me at work and I was really upset. They asked me to meet the family doctor and know the system. They could have told me she had to go someplace else. They couldn't even transport her."

"They need to have an ophthalmologist."

> Patients from Seuf denied using other clinics in addition to Seuf, while patients at non-pilot units all said they use other clinics (private and public).

"*I do not go elsewhere now. My household is in need of the money I would spend on other clinics in addition to what I would have to spend on transportation."*

> Pilot patients indicate very good reception by all staff at Seuf Family Health Center (contrary to non-pilot sites).

"They are very patient and answer all my questions and take time to alert us to important things we are not aware of."

"Every time we come, they sit and talk with us."

"They make us feel comfortable with them. They are all good to us, especially the physicians."

> Pilot patients do not use services after dark.

"*The place is not safe at night." "They should care more about the outside*."

> Pilot patients indicated that prescribed medicine is not always available and, when it is not, they get it from outside. However, all expressed satisfaction with the pharmacists at the center who explain things to them clearly and who are helpful.

> Patients do not like long waiting times and prefer an appointment system by phone. Some patients indicated they are willing to pay more to avoid waiting lines, as they do at private clinics. (*Note*: Patients at Seuf have to line up in the morning to get an appointment for that

day and if they come from far they wait at the center anyway; at other sites there is no appointment system and the majority arrive in the morning causing a massive crunch. It has been suggested that the morning crunch is at least partly due to the fact that at many public sites drugs run out by the afternoon and people have no idea how long they will have to wait to get attention, so they prefer to come in the morning.)

"There should be a fence outside and the garbage removed, and an umbrella [canopy] installed. We come at 6 AM and have to wait outside until the center is opened."

"I come in the morning at 8. When I get my ticket they tell me to come back for an exam at 11. Either I go back home or I wait here instead of going home and having to come back later."

"If I come late, I am told all appointments for the day have been reserved,'come tomorrow'. My daughter took the day off from school to come here."

"Those who are close to the unit can come to reserve. Those who are too far have a problem."

"It would be very good to reserve by phone."

"Call from any shop and come at the appointment time".

"I come at 8 and wait until 3. It's a long way for me so I go to the Director for help."

"I would like the files to take less time."

> Patients would like to have more health education information and materials (visual aids, pamphlets, and videos.)

"*They don't have any pictures, or booklets to give us."*

"They just talk to us and explain things by words."

"They showed us a video when the governor came."

"Videotapes are very valuable."

> Patients at sites other than Seuf and at non-pilot sites also complained of cramped space or no space in waiting rooms, and particularly for mothers with small children. This problem is exacerbated by the lack of appointment systems.

3.2 Willingness and Ability to Pay

> Most patients with insurance go to HIO clinics even if their non-insured family members go to a pilot site because if their case requires referral it will be covered by the insurance; yet they recognize better quality of care and service at the pilot site (Seuf). Patients with insurance or a salaried spouse would like monthly payroll deductions (including for any roster fee) to cover the whole family; unsalaried patients prefer to pay as they go (per visit).

> A few non-insured pilot patients admitted that they go to Seuf because they save money and used to pay more at private clinics and pharmacies.

"*We save so much money by coming here*."

"It's better here and cheaper."

"We brought all our neighbors to register and many of them felt comfortable. First of all, the ticket price is reasonable."

- Some patients are willing to pay more and would pay an annual roster fee but then not expect to pay any other visit fees. On the other hand, some patients were very apprehensive about having to pay more visit fees or to make a lump-sum payment and said they could not afford any higher fees.

"In other places the examination is for 5 LE and the treatment [medication] for 10 LE, so it's no use going there."

"I would not come. I would die."

" We left the hospital, the polyclinic and everything to come here because they said we would not pay so much."

"We like it the way it is now."

"If we pay per month, we would come whether or not we are sick."

"If I have to, I would pay a bit more."

"Fifty LE is the maximum anyone should have to pay for a year."

"In spite of the good services here, people would go to any other center that is close to them because of the people's economic condition."

"Widows, the fatherless, divorced women, people on small pensions, the jobless or no regular work, handicapped, should get services for free."

"If I had to pay for my medicine, I would go home. I don't have money."

"I would pay if it is less than the market price, which is expensive".

- Insured males are willing to pay between 3 LE and 5 LE per visit. (This is what some private clinics in the area charge.)

- Non-pilot uninsured patients say they pay a lot to private doctors and pharmacies, in particular, and would be willing to pay for better quality and drugs.

"I come here for diabetes medication. They test the blood sugar level here every three months while it is supposed to be tested monthly. So I have to go and have it tested elsewhere."

"*I save money coming here because it is cheaper. However, I do not come here often, the medication they give is limited, and usually I go to a private clinic."*

- All pilot patients believe the lab and x-ray fees at Seuf Family Health Center are high (higher or as high as neighboring private providers).

"When I can't afford it, I don't do the tests and I just take the medicine."

"I wish they would reduce the lab prices a little bit."

"It costs 4 LE outside and here too. Sometime you find it for less outside. It's better to reduce prices so we can do the tests and get the medicine here too."

"Yes the care is complete, and clean, but they should reduce the price of the analysis".

- At Seuf, participants reported an amount spent per month on each member of the family between 1 LE and 20 LE for examinations and between 5 LE and 10 LE for drugs (obtained at Seuf).

- Non-pilot patients reported monthly health family spending ranged between 30 LE and 50 LE for examinations and less than 30 LE for medicine.

"The least money we pay for the children is 20 LE per month, depending on the state of their health." (MOHP)

"It depends on the circumstances, my husband pays around 50 LE." (MOHP)

"It costs 20 LE monthly for the regular treatment (out of pocket) but with the insurance it costs 50 LE yearly." (HIO)

3.3 Raising Awareness of Improved Services and New Insurance

Prototype logos were drawn up for testing with a view to preparing a brand identity and marketing campaign for insurance enrollment and increased use of pilot sites. Such a campaign to create demand could be launched once the accreditation system and social insurance fund were operational and the pilot sites covered more districts. It was thought that a logo denoting a "quality seal of approval" would be placed on accredited facilities participating in the new social insurance fund and also serve as a seal of approval for health information and other related uses, for example, participating private provider networks. Secondly, the logo would serve to build an "identity" for the new social insurance fund as distinct from the MOHP and HIO. Most patients indicated before viewing the drawings that they were familiar with the Goldstar Family Planning clinic quality logo. (A successful MOHP marketing campaign funded by USAID to increase use of safe, reliable family planning clinics. Many MOHP units exhibit the goldstar symbol alongside a logo of an adult and two children.)

Patients were presented three variations of a drawing showing two adults and two children sheltered by a red crescent (symbol of health care used much like the red cross in the United States) and the words in Arabic "Family Health Fund."

- Patients (and providers) saw "family planning" as the message and suggested either adding grandparents/a doctor and nurse/a baby and pregnant female.

"Only one boy and one girl is enough, this must be family planning!"

"A small family is excellent for good care."

> Patients also saw "*trust*" and "*mercy*" in the symbol (the crescent was positioned protectively over the family or supportively under the family rather than in the traditional lateral way precisely to suggest these connotations).

3.4 Non-pilot Patient Perspectives on the Current MOHP and HIO System

> Male HIO non-pilot patients commented:

"If I go to a specialist in his private clinic, although I will pay extra money, I will be examined immediately."

"The employees who receive our medical ID usually treat us badly and the receptionists treat us according to their mood."

"The doctor is too busy to speak with the patients."

"The GP does not hear my complaint and just refers me to the specialist."

"The consultants refer the patients to each other like a ball in a game."

"They must cancel the ten day examination system for the chronic and return to monthly visits in order to relieve pressure on the clinics."

"The HIO advantages are better in case a patient needs an operation."

"If we overcome the negative aspects of the HIO and all the family can contribute to the HIO system, it would be one of the best systems."

> Female MOHP non-pilot patients commented:

"I do not find the medicine most of the time."

"I spend a lot of money on drugs."

"It saves money, but I come here little. I go to a private doctor."

"I trust pharmacists outside because they give me the medicine right away. They explain more."

"There are good and bad doctors."

"I speak to the doctor only when he allows me."

"I have not been examined by the physician using a stethoscope since 1992. He is always in a hurry."

"We have no health education, only family planning cares about us."

"The room is clean and the bed is clean, only the physician does not examine the patient on the bed. He listens to what he says by mouth and writes the prescription."

"A multitude of patients, at least 50 per doctor, plus those who pretend to be ill."

4. Findings: Social Worker Perspectives on Patient Satisfaction and Willingness and Ability to Pay (all sites)

The responses from the session with social workers from the pilot sites confirmed many of the responses from patients or those of the other provider sessions and the overriding fact that patients did value the family health services and did perceive the improved quality of care.

- Social workers have diverse opportunities to get to know the patients and appear to have the trust of the patients. Complaints are handled by the social workers and they are responsible for awarding exemptions from fees based on their interviews with patients and any follow-up investigation they do. Social workers do community outreach and health promotion and fund-raise for donations to cover the costs of the very poor, drugs, or needed supplies.

"*The social worker is considered a neutral party, so patients come to us and tell us everything. The relationship between us is good."*

- Social workers (who participate in the registration of all new patients) confirmed that patients appreciate the value of having medical records.

"*At the beginning they were not happy, but with time they felt the importance of these files to them."*

- Social workers from pilot sites bordering the neighboring governorate of Behera were the first to raise attention to intergovernorate issues. Patients with legal residence in Behera were seeking treatment at the pilot units (primarily Gon and Khorshed Health units). They were obliged to pay higher fees (3 LE) rather than the usual 1 LE fee and were asked to pay for medicine, which residents of Alexandria governorate did not pay for at those units particularly when social workers were successful in raising donations from pharmaceutical companies or private sponsors. While this problem might be resolved over time with start-up of more family health clinics in Behera, it signaled other policy issues the governorates would eventually face concerning health records, statistics, resources, and patient choice.

- Regarding the referral system, social workers also cited the problem of patients who were referred to but could not afford fees at Shark El Medina hospital, the designated hospital referral site for the pilot and a public facility with a mandate to recover its costs. They confirmed what the other provider sessions stated, i.e., that patients often do not go to referrals to avoid charges or due to the inconvenience of time and travel. They want everything in one place, "one-stop shopping" so to speak (patients confirmed this also).

"A lot of things are very expensive at Shark El Medina Hospital. Patients come back very upset and say for simple procedures they had to pay 500 LE, and they had to borrow the money from their neighbors."

"The problem is that the patient does not go to the specialist he has been assigned to go to; this is a common problem in the rural areas. He comes for the examination with a pound in his pocket; if referred, either he does not have the money or he does not want go far."

"They expect to find everything in the center."

"Patients want ophthalmologists and dermatologists in the centers."

- Regarding access, social workers judged that a close location is most important to most patients.

- Regarding priority services for women, social workers from some sites said family planning was not always available (only on Tuesdays in one unit) and that some women preferred female gynecologists. They also indicated that visit fees affected routine pregnancy follow-up. They noted that medical record forms in the family file were not adequate for pregnancy follow-up.

"*Pregnant women should not have to pay for periodic prenatal check-ups. They won't pay a visit fee every time. Also, when the physician was female, more women came. Now with the new system less are coming."*

- Regarding patient fees, social workers also assert (as do all other provider and patient groups) that pilot fees should be less than private clinics and in line with charges at vertical program centers or units. (Some vertical program services are provided free of charge causing family health patients to seek some services at a vertical program site with which no system exists for record sharing and continuity of care).

"We asked the reception not to charge family planning visitors, but they do not listen. Besides the ticket fee, a family planning patient who comes here for a loop pays 30 LE, and then she also pays for an injection."

- Social workers feared that monthly or yearly payments (for example, a roster fee) would lead patients who do pay it to overuse the facilities and those who cannot afford it to drop out. Social workers believed the patient preferences for payment would be salary deductions, or pay-per-visit. They asserted that many were simply not able to pay. (As word spread of proposed reforms, social workers started to query patients on their own regarding payment.)

"The economic standard is very low. There will be an absolute objection to paying yearly or quarterly."

"A slight increase in the price of the tickets, making them 3 LE and including medicine may be acceptable. But more than this, people will not show up."

"I proposed the idea of a yearly payment at a health education session. Some rejected it and others welcomed it. Those who refused are in the very poor category."

"As for medical insurance, people are ready to pay since part of their salary is already taken; so they don't mind if they pay more but get the service and medicines they need."

"If a patient pays a monthly or yearly payment, he would come without being sick and take the medicines which he can sell and get money."

- Waiting times are an issue for everyone. At clinics where there was no appointment system like that at Seuf, social workers described patient frustration with long waiting times. They cited not only the lack of an appointment system but also the shortage of trained doctors,

nurses, and even pharmacists to replace family health staff either on leave, sick, or at the routine MOHP district and governorate training sessions. Record-keeping requirements also added to the wait. Social workers at sites other than Seuf also complained that bathrooms were kept closed and patients only allowed to use them for tests. (This could also add to patient frustration about long waiting times as well.)

"Waiting time is long; so we use it to show a video and explain health subjects."

"Sometimes we have only one physician who has to see a lot of patients who obtained tickets early in the morning. Other physicians are either attending a training seminar or on leave."

"We have a problem. The waiting room is too small and no chairs available. When it rains or is very hot…"

"We have two restrooms. One for male and one for female. The maintenance close them and only open them for lab tests."

"Patients would not pay more because they rather go to a private physician where they would not have to wait so long."

> Regarding health education and awareness, social workers want more audio-visual and print aids to help in their health promotion efforts.

"*We have a family club room but lack some films and graphic publications. We also need a teaching kitchen to demonstrate healthy meals and cooking for the family."*

"We don't have posters. It is much easier to remember pictures than words."

"At the [HIO] pilot center, we don't get any support from any social center."

5. Findings: Provider Perspectives on Professional Quality including Service Delivery, Operations, Administration and Regulation

Provider sessions on questions of professional quality were limited to Seuf Family Health Center doctors, in one session, and nurses and social workers, in another. At the time of the focus groups, the other sites had either just opened (HIO) or had not been operating long enough to provide any significant monitoring feedback. Furthermore, Seuf, as the pilot's demonstration site, represented the best gauge in this regard.

5.1 Professional Quality and Management: Physicians (Seuf only)

Male and female family physicians expressed satisfaction with the new family practice approach and acknowledged that patients were happier and they took pride in giving good quality care. Following are their suggestions for improvements and adjustments to the pilot model. (See also Annex E for a SWOT analysis of the results of the provider sessions by a member of the TSO who observed the sessions with doctors and nurses.)

- All expressed a desire for practical training and continuing medical education (they had received theoretical training), particularly in the areas of family planning and reproductive health, followed by emergency services and cardiology. (The doctors in the pilot site were previously specialists in one discipline or another or general practitioners and had uneven experience with these areas of medicine that they as family doctors were now expected to deal with and only refer complicated cases or cases that require more investigation.)

"I benefited from the training programs, but I wish there were practical training. I am an internist and now gynecology is required. How can I learn everything in two days?"

"Cardiology and neonatal courses were lacking practical aspects."

"Now I need practical training. All training programs were theoretical, nothing practical. We are missing practical [clinical] training."

"They gave us important information on the bases of the family doctor system, its nature and how it works."

- Related to the need for practical training, they cited the need for access to a telephone for consultations with specialists and for emergency cases. There are no emergency personnel, no telephone, and no ambulance. Physicians noted that they had to deal with emergency cases as well as the regular roster.

"We have no ambulance, no telephone. We have a walkie-talkie. We can't reach the nearest ambulance in less than 20 minutes due to the traffic."

- They stated they would like to have access to a computer (and Internet) as well as the time to do research on special cases on their family roster.

- Regarding referrals, physicians noted the patient preference for specialists on site (at Seuf Family Health Center an ob/gyn, internist, and pediatrician are on site) and suggested a rotation of diverse specialists (ophthalmologists, dermatologists, ENT, as well as ob/gyn, pediatricians, and internists) among the family health units on designated days.

"We need to get more specialists in some fields like dermatology, ENT, and ophthalmology to work with us in the same center to ease referral of such cases. Those specialists do not have to come to the center everyday. They can rotate and that way the center can afford them."

- Physicians observed that many patients did not follow up on referrals (for reasons cited in the patient perspectives above) and that as the referral system was not well established or coordinated there was not adequate record sharing for follow-up. The physicians suggested that the referral system records should be accessible on a computer network.

"When the patient finds out it is far, he doesn't go. He either doesn't go, doesn't buy the medicines, or he goes to a private doctor. Yet it costs him more to go to the private doctor and buy the drugs outside."

"Most patients come from a very low social status and have very meager financial means. When we refer them to Shark El Medina Hospital they find the fees unaffordable and end up coming back to us."

"Patients are poor and cannot afford being referred to other physicians so they keep coming back again."

"Feedback on referrals we make is limited to 'recovered,' 'improved,' 'died'." How can I enter data on the computer with these choices?"

"People who receive our referred patients know nothing about Family Medicine. They should understand what we do…so that the patients are well taken care of".

"They trust me and know that I'll do the best for them. But problems arise when I refer them to another physician or when I send them to another place and they don't get the expected service."

"Our problem is that the system is not clear to anybody; to the patients, to the hospital, and not even to us."

- Record keeping was problematic and overly burdensome. They complained that forms are not adequately designed and they need special forms for reproductive age women and for children. They are asked to report data for the MOHP and many vertical programs, which needs to be consolidated. They were apprehensive about patient dissatisfaction with long waiting times due partly to their record-keeping duties for each patient. (Also cited in patient and social worker sessions.) Based on their experience, physicians suggested that further pilot clinics not be opened for operation until the computer record system was in place.

"Medical records are excessive, exaggerated, and too far stretched to a horrifying extent. We and the nursing supervisors are really suffering from this issue."

"We keep writing. We spend 15 minutes with the patient and it takes us from seven to ten minutes continuous writing. The patient wonders! Later, I have to input all the data into the computer."

"Patients complain that the physician is writing all the time. You are wasting our time."

"The space for writing in the form is too small and items are not even clear."

"Although the computer is available, the necessary software is lacking."

"I need computer data on number of patients, sorted out by females and males, how many of reproductive age. All this we have to do manually!"

- The physicians acknowledged that the family health sites were better equipped than the average MOHP site but that nevertheless some diagnostic equipment and basic supplies were lacking. (One example is that they had to take up a collection to pay for blankets for patients when the weather turned cold. It is not clear whether this is due to their "out of the system" status.)

- Prescribing restrictions are too rigid, and this frustrated physicians with elderly or chronically ill patients. To get around the restriction on two prescription drugs per patient, they would sell two tickets to one patient to allow them to have three or four needed prescriptions. Chronically ill patients such as diabetics had to return and pay visit fees just to renew their insulin prescriptions.

"We have many cases that are ischemic, hypertensive, or diabetic and they need four or five drugs."

"Some of the medicines in the guidelines are not included on the MOHP list."

- Physicians also noted the lack of security at night at the facilities that the other focus groups cited.

"Patients are afraid to come after 5 PM".

"The area is dark".

- As newly practicing family physicians in a system to which the discipline is new, the physicians said there should be promotion of the discipline and awareness raised among the professions about Family Medicine and among the public about the family health approach.

"We can increase the number of patients and have them trust the family practitioner by raising the status of the family practice specialist in terms of general awareness and in relation to other specialists."

- Last but not least, the anger and resentment voiced by the physicians (and nurses and social workers) who had not received their regular incentive payments in many months is hard to depict on paper. They did not take it out on the patients but they did blame the "system" (MOHP and PHR). (Discontented providers admitted having "sick-outs" and refusing to comply with accurate and timely data collection. All threatened to quit and only upon a collective letter of resignation, did they receive partial payment of the incentive payments

due them.) All the provider groups complained that they were working harder and longer hours than before, travelling much longer distances from their homes, *for less pay.*

" We joined this project on the grounds that we will improve our income and at the same time offer a better service we can be proud of."

"How can we trust the Ministry? We have lost our dignity as physicians."

"Now I have to take two different types of transportation to get here."

"PHR promised us in October 1999 they will start discussing the contract with us, we are now in February so what is the problem? There should have been a representative from the Ministry, but it seems they deceived us; after we started working, they ignored the contracts issue."

"We had to go through a selection process and from 50 or 60 they chose seven or eight of us, which means we are the best."

"I do not care to go on summer holidays, I only wish to provide for my family everyday living expenses and tutoring for the children, which add up to more than 2000 LE."

"We left good positions and post-graduate studies. We were told we would be paid a minimum of 1500 LE per month and more based on our work and the cases we complete. None of this happening."

"We know they are putting millions into fixing the buildings; why not invest in us?"

Note: This problem can be avoided in the future. It is disruptive to the pilot process and harmful to MOHP efforts to recruit the best and the brightest public, private, and NGO physicians to take up family practice. In theory, the establishment of the Family Health Fund and the performance-based incentive system will avoid this in the future; but the Fund was not in place at the time of the start-up of the pilot clinics. The MOHP did commit to making the incentive payments at the time of the pilot start-up and had budgeted for the incentive payments out of funds it was due from the Ministry of Finance; however, those funds proved to be very difficult for the MOHP to access.

5.2 Professional Quality and Management: Nurses and Social Workers (Seuf only)

Nurses and social workers attested to the smooth and good relations with patients, in contrast with the existing system where the interaction between patients and providers can be contentious. Following are their suggestions for improvements and adjustments to the pilot model.

> Nurses and social workers lamented that training in general is geared to the physicians. Nurses asked for training on the new equipment. They also suggested the need for manuals or guides on quality procedures in addition to one they have on infection control.

"*We would like to receive training in quality improvement and on the computers."*

> Regarding the referral problems cited above by doctors and patients, this group suggested arranging referrals to nearby and low-cost sites and training them in the family file and record-keeping system.

"Sometimes I have to send children with speech problems to places not affiliated with our referral system since this specialty is not available at Shark El Medina Hospital. Those places do not report them back because there are no communication channels between us."

"If we provided a comprehensive, integrated service at the centers it would save the patients the effort of going other places; and even if they need to be referred, it should be to a nearby hospital at reasonable prices."

> They confirmed the physicians' observations that supplies (for example, for infection control), equipment, transportation and funds are lacking. Maintenance is too short-handed. They participated in the fundraising for blankets and bring soap to wash their hands from home.

"*We do not have an ambulance. We only have a delivery car for women in labor and it is only available on the morning shift."*

"The fact there is no budget causes us problems."

"Emergency is not adequately supplied. We need salt solutions for hypertensive patients. We don't have a suction machine. Yet we have all this equipment I don't know what we're supposed to do with it. We don't have emergency nurses."

" If a kid needs a suture, I need needles, tray, thread."

> The staffing shortages affect this group, as many have to work double-shifts or take on extra responsibilities, or carry the double burden of absent colleagues. They emphasized a shortage of specialists, family doctors, nurses, emergency, security, and cleaning and maintenance personnel.

"There must be security available because it is completely unsafe here, especially at night."

"We need an ambulance on call at the unit. We are in the year 2000!"

"When a nurse is absent, there is no one to replace her, and it becomes a big problem".

"Patients want emergency services to start after dark at 6 PM."

"We need an emergency specialist. When we have a delivery, the person on temporary duty from the hospital can't handle it because he's a surgeon and he depends on the nurse to do it all alone. The same happens when someone comes with chest pains; he just refers it. When there is a fracture, he can't handle it. He cannot handle pediatric asthmatic cases that need adjustment of the doses."

" It happened twice that they sent us a physician who was psychologically disturbed. His hospital needed to get rid of him. He caused a lot of trouble and we had a hard time getting rid of him."

> They are also burdened by the record-keeping requirements and related problems. Nurses and social workers echoed the physicians' complaints that the forms lack space for items such as deliveries, prenatal care, emergency, inpatient, and vaccinations. They too would like to see the vertical program requirements consolidated. (The MOHP did form a workgroup to resolve this problem.)

"Paperwork takes a lot of time…we have never seen this amount of writing."

"We still do the statistics manually and it takes too much effort."

"There should be a card for vaccinations and for prenatal care."

"There is no space to write on the forms."

"All the requirements for the Ministry should merge."

> This group is responsible for most of the health education and promotion and requested more materials and aids to do this work.

"*Each of us is responsible for a school around us; we find the students know nothing about health awareness."*

"The problems we have are poverty, ignorance, and diseases."

> Social workers confirmed that two tickets are sold to patients requiring more than two drugs to get around the restriction on two prescription drugs per person (per visit).

> The group expressed a collective desire to have more opportunity to talk with the TSO and have their recommendations heard.

"*Thank God we are a cooperative group and we give good service but we want to meet with the people from the TSO at the MOHP. We never meet while they are in Alexandria; they never ask us about our obstacles and the problems we are facing*".

"*They only come and stay for five or ten minutes and they leave and never think of asking us what is bothering us."*

"I am the head of the complaints committee but these complaints never reach the TSO."

> Regarding the contentious issue of overdue incentive payments that was negatively affecting the whole staff, social workers remarked about the added costs of transportation and travel time to remote pilot sites. In addition, they voiced their decreasing enthusiasm and faith in the project:

"*Before I was working extra and making enough money, but now I comfort people while I myself am in trouble."*

"Some of us used to have second job and we left it. They don't pay us overtime. They don't pay us extra for the night shift and we even work on Fridays."

"They have promised us money (250 LE) and everyday they say 'tomorrow'."

"Before, I worked extra outside. Now we cannot."

"I ask for my legal right. They owe me money that I need to spend on my family."

"I was promised a better job than before and so it is not fair that after eight or nine months I am not paid what I was promised at the beginning."

"I should be given a chance to work outside and not just sit there all evening to interview one patient."

"It takes me one hour and a half to come and go; three hours. What compensation do I get for this loss and the transportation costs?"

"We are asked to perform perfectly with a high quality and satisfy the patients so we should be looked after; otherwise they shouldn't blame us for anything that goes wrong."

"All those who work for Family Medicine have lost."

5.3 Professional Quality and Management: Pharmacists (all sites)

Pharmacists at the pilot sites had not received family practice orientation or any special training in the context of the pilot but they were supportive of the approach. Their suggestions are as follows:

> Pharmacists would like to feel included in the family health program.

"I like it but we don't get anything out of it."

> They were supportive of the pilot objectives and all attested to a good, cooperative relationship with the teams. They also noted that patients pay an average of 10 LE on drugs per visit but that there are many cases of people who cannot pay and there is no subsidy from social assistance for these cases.

> There is poor or no coordination between pharmacists on different shifts or at different sites. HIO has a completely different record-keeping system from the MOHP and they hope computerization will conform the two systems eventually.

"*There ought to be a manager who coordinates our work and the use of resources."*

"Now I have to keep two types of forms."

"We could use a better record-keeping system on computers."

> They often need to find their own transportation to warehouses to replenish supplies.

"When there is a shortage of some item I sometimes have to go purchase it myself and I pay for the transportation."

"If there were a car it would save a lot of time."

> There is insufficient work and storage space and inadequate ventilation.

"*What's all this fuss about supplies? Where do they want me to put it? I told the director I won't order an item until there is a proper place to store it.*"

> There is often a shortage of drugs typically prescribed for chronic diseases such as diabetes

and hypertension.

- There is a critical shortage of pharmacists in the MOHP system and in the pilot as a result.

"Working hours are long and the government used to pay overtime…no more."

"In the agricultural areas no one comes at night; women can't come and most of the staff is female."

"Why can't we determine working hours according to when the patients come?"

"We don't have assistants and there is only one pharmacist."

"Why would anyone work for the government for 250 LE a month when he can get 10 times that in a pharmacy or at a drug company?"

"Transportation expenses to get to these pilot sites are expensive."

5.4 Professional Quality and Management: Pilot Clinic Directors (2 centers and 3 units)

The session with the managers of the five pilot sites was particularly informative and elaborated on many of the comments made at other provider and patient sessions.

- An issue that is specific to this group regards their roles as directors of the sites (and contracting with the Fund). They emphasized how much time it takes to administrate, to try to get the existing health system administration to respond to their needs and problems, and to fulfill their public health obligations as heads of the facilities, such as witnessing death certificates, among others. They were firm in their conviction that they cannot be expected to manage both a family roster and the facilities and personnel. They suggested they should have job descriptions and clear incentives outlined for their positions in the new system.

"*Administration alone is a full-time job."*

- As directors and those responsible for liaison and interaction with the greater health system they cited the need for a "family health authority" to be established in the MOHP and corresponding to the district, governorate, and central levels of the health system. (The TSO as a unit formed to provide operational, procurement, and technical support to the reform program is not a permanent management solution and it is outside the regular health bureaucracy.)

"*When you go to the Directorate they say ' you have a lot of money, why are you coming to us?'"*

"*They have stopped paying for supplies. Who will now pay for the computer paper and ink and the maintenance*?"

"*Is there any administration for the Family Medicine system? Where should we go*? *Where do we ask about the family physician*?"

- Regarding operations of the sites the directors stated the following needs:

- Electric generators in the units: “Power shortages often happen at day and at night. The operating rooms, delivery, emergency, vaccines all need this.” “I was told by the MOHP to ‘take it out of the Center’s revenues’.”
- Emergency transportation and telephone lines: For example, there is only one car for emergency deliveries and it is only available in the mornings. There is a walkie-talkie to phone for an ambulance for emergencies but cars are often far away or too slow to respond, particularly given the remote location of the sites. The HIO Abu Qir Family Center is the only one adjacent to a hospital.
- Funds for miscellaneous expenses and supplies (such as light bulbs, chlorine for infection control, blankets, flashlights, garbage bags, soap) and to meet accreditation standards. (A unit currently receives 50 LE–70 LE per month to cover all supplies and expenses including transportation to buy urgent supplies, send reports to the directorate, witness a case of death at a home.): Such funds would help avoid a tedious and sluggish central procurement process the clinics are forced to use and facilitate access to items not yet part of the “regular” system, for example, printing of tickets for people who line up to get an appointment. (*Note*: clinics are allowed to retain a percentage of user fees for these supplies and transportation; the complaint is that the amount is not sufficient to cover the operations.)

“*Price offers can take up to 4 months to get processed.”*

“I can’t go out and buy 50 light bulbs when they go out. I have to call a board meeting that takes 10-15 days. Once I get board approval I have to go through the procurement procedure to get a purchase order.”

“I receive revenue of 7,000-8,000LE per month. 48 percent is for the employees; 12 percent for the Ministry and the Directorate; and 40 percent for our facility and this does not cover all our needs”.

- Summer and winter uniforms
- Washer for bedsheets
- Training on equipment in the sites (particularly emergency equipment; some units are missing basic emergency equipment like oxygen sets)
- Computer support, maintenance, and supplies
- Better security for buildings and at night

“We requested it officially from the police but they refused.”

- More and better health education and promotion materials and aids

“Health education and preventive medicine have not started in some of our units.”

- More storage space for the family files

> Directors sited the pharmaceutical quota system and lack of storage space as the cause of drug shortages and particularly for chronic illnesses.

“*We have a monthly quota which is consumed in a week.”*

> They cited a critical shortage of pharmacists and emergency personnel as well as the general shortage of qualified staff to work under the pilot model. (This exacerbates the problem of long waiting times for patients when all staff is not present whether due to being

sent to routine MOHP district and governorate-sponsored training or to leave).

- Practical training in family planning and reproductive health for the family doctors is of great concern for them. (This reflects physicians' requests in other sessions). They would like to have experts come to the sites and guide family doctors as they treat and counsel patients and demonstrate how to insert an IUD and perform other similar routine interventions that should not require referral.

"*If a woman wants a loop, a physician may convince her that pills are better because he is not sure of himself. I have heard lectures on it but never done it myself."*

"*A family planning mobile van has parked outside our door. It serves family planning cases rapidly at no charge. In five minutes, a case can get the required service and leave immediately."*

- Also echoing the statements of the providers, the directors discussed the disorganization of the referral system, the fact that Shark El Medina (referral site for Seuf, Mohsen, and Gon) charges too much, and that patients refuse to go.

"*Patients tear up the referral forms when I send them to Shark and then go to Kafr El-Dawar Hospital."*

"*When a patient needs an operation and is referred to a specialist at Abu Qir hospital (HIO), he may have to wait months for his turn, and also have to make a down payment."* (Abu Qir is the referral site for Abu Qir Family Health Center and for the MOHP Khorshed Family Health Unit.)

"*Specialists have to have an incentive for this.*"

"*It is a personal effort system. No rules, no regulation, no discipline.*"

"*Abu Qir doesn't even have any x-ray equipment.*"

- Directors also described the redundancy and inefficiency of the record-keeping system and recommended that computer systems be in place and staff trained before start-up of a site.

"An appropriate computer program can save out time and effort and money wasted in attempting to complete all these forms with identical data in many of them." "My work is making files, everyone wants files."

- Regarding the private sector, directors felt that private participation in the pilot should involve cooperation and coordination with public sites, and not competition (or they fear they will lose patients).

- In relation to the above, the directors also cited the need to promote the practice of Family Medicine and to promote the family health approach in the communities.

- Regarding patient charges, the directors believed there should be fees to deter patients from overusing drugs and self-medicating, a problem prevalent particularly in the low-income population (who seek to avoid physician fees and/or save time by going straight to pharmacists to obtain medicine). Some directors cited cases of patients registering at more than one site to get and resell free drugs. Others borrow ID cards to get drugs. They suggest a photo ID system be installed at facilities because it not easy or it is too expensive for a family to obtain ID photos of every member. (*Note*: Drug fee policies vary across HIO and

MOHP sites. This recommendation interestingly appears to be contradictory to private physicians [below] who suggest that drug charges be included in fees for family health services to attract the population.)

- They also believe that if 3 LE are charged and include drugs, patients will be willing to pay (as opposed to just 1 LE for a visit with additional charge for drugs).

"*Sometimes the physician pays for the price of medicine and gives it to the patient."*

- The directors believe people will pay as long as they get service and that good 'word of mouth' is important. They also recognize that not everyone can pay, that there has to be an exemption system in place, and that, as public clinics, they should not turn anyone away. They feel there should be an MOHP information campaign to explain the new system and allow people who prefer to stick with the old to go to those facilities, understanding that the new family health facilities cost more. (This way people cannot say the government is denying them access; this follows the rationale of the upscale private wings in public hospitals, which charge more.)

- Regarding the Family Health Fund, they were apprehensive about contracting with the Fund until the referral system was well organized. They stated they had no problem with performance measures, as long as they were objectively measurable.

- The directors had many ideas for promotion of the importance of family doctors in the community and suggested the MOHP should announce the new pilot system and the differences with the old.

- All the directors recognized the importance of quality assurance, its connection with patient satisfaction and the importance of the facility accreditation. However they cited the need for funds to be able to maintain and improve quality.

"You need to have funds put aside with enough cash to replenish chlorine and other materials used for infection control."

"The question that needs answering is 'How much does quality cost'?"

- As directors this groups has to deal with morale and performance issues. Regarding the non-payment of incentives, one director succinctly put it "*A credible system of incentives has to be established."* Another director worried "*The project is losing its credibility.*" "*The proposed salary is 1500-2000 LE, not 250 LE.*"

Box 2. Health Worker Motivation

Synthesizing the feedback from the focus group sessions with physicians (including directors of the pilot sites who are all physicians), nurses, and social workers highlighted the following monetary and non-monetary factors as important to their motivation as health care providers:

> Payment incentives, including overtime

> Practical training and continuing medical education

> Professional and public promotion (and recognition) of Family Medicine and the family health approach (professional pride and prestige)

> Patient satisfaction and respect/professional satisfaction

> Time and travel distance to workplace

> Channels for feedback and opinions to be heard

> Reduced paperwork burden

> Desire to help the poor

Groups such as pharmacists and dentists who were not the object of training in the first phases of the pilot but who operate at family health centers expressed a desire "to feel included."

5.5 Raising Awareness of Improved Services and New Insurance: Physicians, Nurses, Social Workers

Every focus group was queried about the logo to potentially be used as a seal of quality approval by the Family Health Fund with a brief, general explanation of the Fund's future function in the pilot as a new kind of insurance. Each group was shown three variations of one drawing with three main components in the drawing: two adults and two children (a family); a red crescent (symbol of medical attention); and the words in Arabic "Family Health Fund." The crescent was positioned either over the family (as a shelter) or under the family (as a support). The third variation was in the type of lettering (for reactions from functionally illiterate patients).

> **Nurses:** Some of the nurses felt the drawing implied family planning. The group shared the notion that the word "Fund" indicates "money collection" or the "material aspects" only and that they like the expression "family health." Two suggested alternative drawings with an elderly member and a pregnant female.

> **Social Workers:** Social workers questioned whether the meaning of the word "Fund" is clear. They suggested changing the word to "care" or "medicine". They also suggested adding "grandparents" or a "doctor and nurse" to the logo drawing to distinguish it from a family planning logo (as the drawing only has two children).

- **Pilot Directors:** Some of the directors shared the opinion of other groups that the word "Fund" is misleading. For the logo, one suggested using an eagle with extended wings to protect a family, as the eagle is the symbol of Egypt and the MOHP. (Other physician sessions were not queried on this point.)

6. Findings: Provider Willingness to Contract with the Family Health Fund

6.1 Public Providers (all pilot sites)

Moderators reviewed with participants the proposed performance-based measures to be included in a contract with the Family Health Fund and the eventual payment of incentives.

> Providers (physicians and nurses) believe the assigned roster number (600 families) with the expectation of seeing 15-20 patients per day is appropriate although some cited having to see 20-30. The problem is the crunch, as most patients prefer to come in the morning. The afternoon shift is slow. No patients come after dark, which suggests a need to review the evening operating hours or provide better security. Some physicians also indicated that patients roster at more than one clinic; others just roster to hold a place but do not actually use the facility. Some are insured and go to HIO while uninsured family members, mostly female and infants or the elderly, use the pilot facilities; others prefer private doctors but in case they can't afford the expense want to have access to the public family health services. Providers would like to have more patients to offset the latter cases.

"Only 50 percent of those who have registered come back."

"Some came here only to have a file opened for them but they go to other places for treatment and don't come back frequently."

"People only come on the morning shift."

> Providers indicated a preference for a fixed base salary according to years of experience (between 1000 LE and 1500 LE for a newly graduated physician; not less than 300 LE for nurses, doubling according to every two to three years of more experience; not less than 3000 LE for newly graduated and up to 5000 LE for experienced specialists) with incentives for overtime and for surpassing the usual roster number (many are working two shifts).

> Providers want the MOHP to conduct a public awareness campaign about the new family health approach and system. (Patients will not understand why they have to see a family doctor before going to a specialist; or it is too hard to explain to every patient. It also is important for acceptance of the Family Medicine discipline as a specialty.)

> Regarding fees, the public providers believe the competitive advantage is to charge less than other neighboring places; but charge more than customary, current MOHP fees at the start-up of the pilot operation.

> Physicians want time to research cases and for continuing medical education.

> Providers want less paperwork (less waste of time).

- Providers need more information on the incentive criteria for supervisors or administrators.
- Performance criteria should be weighted:
  - Per capita (monthly)
  - Punctuality and attendance
  - Participation in site clinic committees (e.g., quality improvement)
  - Patient satisfaction
  - Referral rate (provided diagnostic tools are available at units and centers)
  - Drug prescription rate
- A common question raised was why are dentists excluded from this program?

6.2 NGO Provider

Unfortunately, only one NGO (a mosque provider in Montazah District) of the three invited agreed to attend the focus group. (Most NGOs in the pilot area correspond to vertical programs; the mosque clinics were one of the few that provided general primary care services. Six representatives from three mosque-sponsored clinics were invited.) Moderators gave a brief orientation on the pilot and the proposed Family Health Fund and then conducted an in-depth interview with the two representatives from the one NGO, a physician and an accountant. The following points summarize their comments.

- Family Medicine is a good and appropriate approach for the primary care reform. The community will like it and will be willing to pay.
- It would be advantageous to be able to focus on one practice in lieu of multiple ones to earn sufficient income.

"The proposed duty time of 6-8 hours daily is excellent. It would release me from suffering time pressures."

- As an NGO provider we would be willing to contract provided:
  - We do not forfeit our pension from the HIO (many doctors are either employed by or contract with the HIO in addition to running their own clinics for additional income)
  - The MOHP provides patients or markets our services to patients.
  - The MOHP provides training to our doctors and recordkeepers.
  - We can use our own internal specialists.
- Suggested base income for a newly graduated physician was 1000 LE per month and a more experience one, 1500 LE per month, and 1700 LE for a specialist. (These rates are roughly half the amounts suggested by private, for-profit providers.) The NGO representative would accept per capita payment in lieu of a fixed base salary.

6.3 Private Providers

Directors of three successful private clinics in the pilot area attended along with a business manager for one of the practices. All had multi-specialty practices, more than adequate facilities for the pilot requirements, and one had a physician trained in Family Medicine on staff.

- The private providers agreed that an average of 15-20 patients per day (as proposed by the Fund) is reasonable. They listed the other performance and incentive criteria they would accept:
  - Per capita payment (above the roster amount)
  - Patient satisfaction
  - Average rate of referral
  - Average rate of prescriptions
- Suitable monthly incomes for a new Family Medicine graduate should be 2500LE, for experienced physicians currently earn around 2000 LE–2500LE; for specialists, 3000 LE–4000 LE. (These rates are more than double those proposed by the NGO participant.)
- Suggested inputs from the MOHP to induce participation by private clinics include:
  - Patient education and marketing about the new family health system and the role of private providers

"Contracting means buying our services. Part of the place will be prepared to affiliate [accredit] with family health and will have some of the required equipment. The Family Health Fund should be responsible for providing the polyclinics, the centers, or the hospitals with the patients."

"The [private] Center will have a dual function. It will have the name of Family Health and serve in a family practice capacity, and at the same time receive patients who are not enrolled in the Family Health Fund."

  - Orientation guidebook and clear procedures outlined as to all the aspects of the Family Health System

"Training should provide a simplified manual that explains everything on the new system and how it is applied. It can serve as a reference on [collecting] monthly statistics and can also serve to orient new physicians to the system."

  - Published notes or a journal on lessons learned from applying Family Medicine in Egypt. (The MOHP with assistance from ECTAT is promoting the establishment of a Family Practice Association for family doctors and nurses.)

"Following training, there should be periodic publications that include any new development in the field of Family Medicine. These should be distributed to all the public and private family practice clinics."

- Private clinics indicated they charge from 3 to 5 LE for a visit. Everything else is additional.
- Private providers wanted more information on the following questions:

- Will drugs be provided the same as the HIO? (They believed including drugs in the fees was important to show some new benefit to patients; otherwise, there was nothing "new" for a private provider whose quality is typically better than that of a public facility).
- What incentives are there for specialists to refer patients to family doctors?
- How will family doctors be tested?
- Can/will the government pay our rates? How will they cover the poor?
- Is government committed to this system after international funding stops?

See the table in Annex B for a synthesis and summary of cross-cutting focus group results by issue area and general suggestions for follow up.

7. Follow-up and Implications for Replication of the Pilot Model

As attested to by the results of all the pilot participant focus groups, providers and patients are highly supportive of the basic premises of the integrated care and family health model and enthusiastic about its continuation. Nevertheless, feedback from the focus group discussions indicates that its strengthening and systematizing can greatly enhance the prospects for replication and sustainability. The notion of family is highly valued in the culture. The prospect of family health care's wide acceptance among the population accompanied by public information and awareness campaigns to improve the image and raise trust in the public health system is promising.

The following conclusions and priorities for follow-up are general suggestions for the establishment of the new model in the health system in the medium to long term. They are based on the focus group discussions. Other stakeholder recommendations, monitoring efforts, and diverse external factors will necessarily be considered as well in planning the pilot's expansion. Adjustments suggested by the focus groups that were possible to accomplish in the short term have either been addressed or are in the process of being addressed by the MOHP with PHR or ECTAT support.

7.1 Policy

7.1.1 Management and Administration

A critical factor for the replication and sustainability of the reforms to integrate services and improve quality through a family practice approach is the institutionalization of the new model in the health system. Management and administration at the central, governorate, and district levels have to have the authority, the flexibility, and the means to respond to the demands of the new model for supplies and equipment, drugs, training, personnel, pharmaceuticals, transportation, telephone and information system, and computer support issues, among others. A recognized authority within the MOHP system can also help to enlist cooperation of vertical programs and the hospital sector and serve as liaison with the HIO-based Family Health Fund or whatever funding mechanism ultimately finances primary care. To date, the new system has had to function and survive under the rules and regulations (and lower standards and budget) of the old system. In sessions with pilot directors, physicians, and nurses, there were repeated references to the need to have a dedicated institutional home within the MOHP.

7.1.2 Health Worker Motivation

In general, the staff at the family health centers and units expressed dedication and those at Seuf Family Health Center take pride in being the demonstration site for the pilot. However, irregular and sporadic payment of their incentive payments caused strong feelings of resentment and regret for having left other MOHP posts where they did receive their incentive payments regularly and which were located closer to their homes. The incentive payment issue threatened the credibility of efforts to recruit more staff to the pilot. (The Family Health Fund had not started operation and therefore the new performance-

based incentive system had not started to replace the traditional MOHP incentive system.) Some staff continued to work overtime at their own or other private clinics to supplement their income.

Furthermore, staff that were sent abroad to special training programs in family practice felt frustrated by the fact that such an investment had been made in them yet they had no channel to give their feedback and suggestions on the pilot. (The focus groups partially address this complaint.) The promotion of Family Medicine throughout the system and to the medical profession is important for the family practice teams to gain recognition and enhance their professional status, pride, and satisfaction.

Pilot site directors needed job descriptions and clear incentives for their newly created positions, and, in the units where they were expected to also serve as the family doctor for a patient roster, they felt overburdened.

7.1.3 Quality Improvement

The new facility accreditation system should be institutionalized within the MOHP, as it contributes to not only sustaining gains in quality but also to health worker motivation. The public is familiar with the concept of accreditation used in family planning programs and accreditation can help to increase use of the family health pilot sites for priority and primary care services. However, lack of accompanying regulatory authority will dilute the impact accreditation adds to the new model. With or without the contracting requirement for accreditation, the accreditation system can succeed if it has an institutional home and if a budget to meet accreditation requirements is provided to the pilot clinics.

7.1.4 Drug Policy, Management, and Fees

This area was too large and complex for PHR to address in its entirety and needs to be the subject of a major policy study in terms of regulation, pricing, distribution, and record keeping. For example, physicians indicated there is a need to revise drug policies in keeping with the quality guidelines and the integrated service approach. Provider sessions also indicated the need to align fees across pilot sites**.** Furthermore**,** MOHP, HIO, and private pharmacists indicate they all use different systems and rules and regulations regarding procurement, pricing, record keeping, stocking, and prescribing, which need rationalizing in the context of the pilot as well as the longer-term sector reform.

7.1.5 Intergovernorate Issues

An example of a cross-border issue is highlighted by the case of patients residing in one governorate but in closer proximity to the pilot sites in another governorate. Their treatment at pilot clinics has implications for record keeping, financing or subsidizing the costs of their treatment, and governorate surveillance and health statistics. Until the pilot is expanded to more sites, an interim plan for addressing such intergovernorate issues has to be developed.

7.1.6 Integration and Coordination with Vertical Programs

Donor-sponsored programs focused on delivering services related to a specific illness or condition have sustained the primary care system and done an admirable job of delivering priority services to women and children and other high risk groups of the population. However, the integrated care model intrinsic to the primary care reform warrants a plan to transition the role of the vertical programs and to

make use of their specialized expertise in the new system. Their cooperation on referrals, record keeping, pricing, health promotion, quality assurance and operations research is very important to the success of the reform. A multi-donor/MOHP/HIO effort needs to plan for a smooth transition for the benefit of the patients and all involved. Providers all expressed their desire for closer cooperation and coordination and their need for practical training by experts from the vertical programs. Provider sessions indicated that unhealthy competition in terms of pricing and record sharing did a disservice to the patients.

7.1.7 Financing

While quantitative and qualitative studies show that the uninsured pay heavily out of pocket for care, there are still policy questions to be answered. Social workers and patients emphasized the need for a fair subsidy policy and test mechanism to be developed and put in place to protect the poor and the poorest. The government has to decide whether to raise user fees, use insurance co-payments or roster fees, or a combination of these or any other public financing alternatives (such as a cigarette tax). A wide range of patient responses indicate more research may be needed on patients' willingness to pay for services at public facilities and the methods of payment.

Another area for testing signaled by both provider and patient groups, and that bridges financing and contracting and possibly vertical program integration, is the feasibility of a multi-specialty model and contracts in the pilot and/or more access to specialists at public sites. Providers suggested rotating or visiting specialists across several sites on a regular basis.

7.1.8 Contracting

At the time of the focus groups too many details remained to be decided for a prototype contract to be shown to the respondents. The performance measures proposed at the time seemed acceptable to the groups as long as credible, transparent measures would be used. Public and NGO providers expected a base salary plus performance incentives. Private providers were willing to accept per capita payments plus other incentives.

Questions and comments from private and NGO providers clearly indicated the need for more detailed and comprehensive briefings by the MOHP. They were clear that if they were to contract with the Family Health Fund they would expect the government to do the marketing and bring covered patients to them. (To receive training and to increase the number of patients were clear incentives for these providers to participate.)

To varying degrees, reluctance or even distrust of contracting with government needs to be overcome by MOHP public relations efforts and systematic and open communication with these providers. (Providers wanted assurances that the government would stick to its commitments to them after donors depart; only one NGO representative attended the NGO session possibly reflecting their skepticism.) The MOHP and HIO should jointly convene consultative and consensus-building briefings with private providers and NGOs in the pilot governorate and also use in-depth interviews, focus groups, or surveys to engage their participation and receive their feedback on proposed policies.

7.2 Operations

7.2.1 Referral System and Information System

Focus group discussions with clinic directors, physicians and nurses indicate the two biggest challenges related to operations of the pilot sites revolve around the establishment of a workable referral system and the development and use of the computer-based information system. Resolution of these issues is exacerbated by the general fragmentation of the current health system. PHR and the MOHP are presently conducting a study to formulate recommendations on strengthening and rationalizing the pilot referral system. Widescale solutions to the establishment of a streamlined information system are dependent on technical assistance and financing from the World Bank whose start-up of operations on the reform program have been delayed. However the MOHP and PHR have begun work to streamline record-keeping and data collection requirements to relieve the burden on providers and to arrange for computer support.

7.2.2 Emergency Services

Patients expect emergency services to be available at all public sites. Staff at family health units and centers want more training in emergency services, access to emergency transportation, and phone lines. Seuf Family Health Center had trouble recruiting and retaining competent emergency personnel, who are not part of the family health pilot program. A clear emergency services policy needs to be outlined for units and centers and any training necessary needs to be provided to physicians and nurses.

7.2.3 Practical Medical Training and Continuing Medical Education for Retrained Family Doctors and Nurses

Family doctors and nurses who had completed a short-term training abroad in family practice principals and management but who had no formal training in Family Medicine all expressed a need for hands-on clinical training in areas that were not their specialty but that they as family providers were now responsible for, such as family planning and reproductive health, and for continuing medical education. In the long term, the MOHP should have a sufficient pool of practitioners trained at university medical school Family Medicine programs. In the short to medium term, however, the MOHP, with donor assistance, can provide practical training to those qualified doctors and nurses who agree to join the family health program. The HIO medical staff have received no training in family practice and need to be included in the MOHP-sponsored training if HIO will continue to deliver primary care services to the insured under the reform program.

7.2.4 Facility Waiting Areas

Small or insufficient waiting area spaces were mentioned by providers and patients at the pilot units as an aggravating problem, particularly for pregnant females, mothers with small children, or the elderly. In the future, it is assumed that new or rehabilitated facilities done under the master plan design for new or renovated facilities will alleviate this problem. Nevertheless, it is suggested that the master plan design be double-checked to ensure enough waiting room space is included. At Seuf Family Health Center, where waiting space is adequate, very poor acoustics made it impossible for those in the waiting areas to hear educational videos broadcast on overhanging monitors.

7.3 Marketing, Health Promotion, and Communications

Given the appeal to patient s of the family health care model, and while the social insurance fund awaits resolution of major policy decisions regarding financing and subsidies and prepares for operation, the MOHP could plan a campaign to promote the concept of family health as part of expanded health education and promotion activities. Such a campaign would serve two objectives: 1) To pave the way for an enrollment campaign for the fund (which would be selling quality, family health services); and 2) To address the need to raise awareness and promote Family Medicine to the professions in the health sector.

Familiarity with the Goldstar quality logo for family planning clinics might indicate a need to incorporate that logo into a redesigned one for the Family Health Fund to build on its extensive marketing in the past and symbolize the concept of integration of services, helping to avoid confusion among patients. Clearly, the focus group responses indicated the need to redesign prototype logos for testing with more focus groups which should also further test the name of the new social insurance entity referred to now as the Family Health Fund.

A question of strategy arises as to whether the logo should be rolled out with the new facility accreditation system, or in the context of the Family Health Fund launch as a corporate logo and seal of approval of facilities, health promotional material, and other uses akin to the uses of the American Medical Association logo in the United States. This question is also relevant to the newly announced Association for Family Practice (provisional name) and its role in promoting the profession and setting standards for family physicians and nurses.

In terms of instituting or raising fees of any type (roster, co-payment, per visit, drugs), a multi-faceted marketing campaign would have to focus on restoring the credibility of public services and programs and the image of quality care at public sites. However, this cannot be done until a sufficient supply of trained or retrained family doctors and nurses are ready for deployment and facilities have been upgraded according to the reform's master plan. Tests on various patient charges and payment methods could be made at one demonstration site to inform policy decisions and inform a subsequent marketing campaign once the new policies are programmed to start.

Nevertheless, there was consensus among the provider and director focus group participants that if user fees are to be raised in the pilot sites, it should be done when the facility starts operation and not after the fact. A "trial period enrollment" may be an option wherein a patient registers for the insurance program and is given a "money-back guarantee" and allowed to try the new services for a short period of a month or two.

7.4 Use of More Qualitative Research to Support Monitoring, Planning and Feedback

Follow-up series of focus groups should be held every six months to continue monitoring different aspects of the pilot as well as patient satisfaction, to allow comparisons over time, and to provide participants in the pilot a mechanism for feedback. At the time of this first series of focus groups some of the pilot clinics and most notably the HIO family health center at Abu Qir had just commenced operation. In addition, more focus groups should be held to receive feedback from political and community representatives in the pilot district and other sectors of the MOHP whose support will be important for the expansion of the pilot. Focus groups and in-depth interviews also can be designed to inform the policy and quantitative studies recommended above in previous sections. Finally, focus

groups or in-depth interviews can be used to either validate or clarify findings of more formal monitoring and evaluation methods and statistics.

Annex A: Moderator Instructions and Tips for Note Takers

The following instructions were prepared by focus group moderators Dr. Ahmed A.R. Mahfouz, High Institute of Public Health, Alexandria University, and Dr. Nadia Mahmoud Soliman, Faculty of Nursing, Alexandria University

Moderator Instructions

> Moderator introduces him/herself

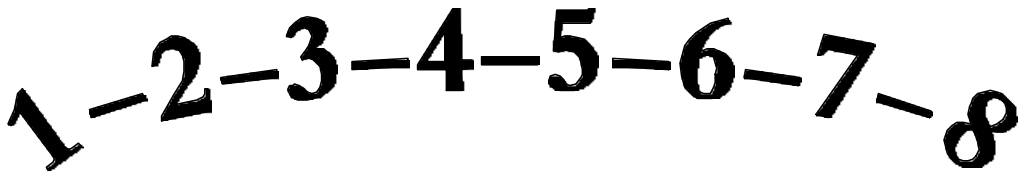
> Explains focus group discussions general objectives, and session special objectives (to each target group).

> Clarifies principles and rules for participating in discussions.

> Requests participants' consent to record the session on tape recorders assuring them that the records will be used only for research purposes.

Data on Session Participants (completed for each individual):

No.	Name	Age	Current Work	Highest Degree Obtained
1				
2				
3				
4				
5				
6				
7				
8				



Tips for the Note Takers

Introduction

The facilitator and the note taker must work as a team and communicate before, during, and after the focus group discussion (FGDs). They need to practice together and give feedback to each other. Don't worry if you can't get everything at first. You will be surprised how quickly you improved. At first, try FGDs with small groups of six to nine people.

We all have different styles for taking notes. Some people have more experience than others. The important thing is to develop a system that works for you. The fol1owing are a few suggestions based on experience that could make your job as a note taker easier.

Before the Session

> Review the *guidelines* carefully with the facilitator.

> Clarify *expectations* with the facilitator: What are you looking for? What ideally and realistically can be recorded?

> Review *vocabulary* and agree upon very short abbreviations for words related to your topic. Review abbreviations for common words.

> Be sure to have *two or three pens*, a writing tablet (lined is best for most people), and something *hard to write on*, like a book or paper holder, since the note taker may not have a table.

> On the *top of each page*, write the date, name of the facilitator and note taker, location of the FGD, and the topic of the FGD. Use only one side of the paper so you can cut and paste later if you need to.

> Think about what kind of *format you will use* to take notes. Some people leave a margin on the left side of the paper for the participant's name. Will you use indentations? Bullets? Numbers? Underlining?

> Invent *nonverbal cues* that you and the facilitator can very discreetly use during the session.

Note taker to facilitator cues:

> Please have the person repeat.

> I can't hear.

> Move on.

> Slow down.

> Ask more about that.

> Time is running short.

- What about x topic?
- Be quiet, let people talk.

Facilitator to note taker cues:

- Did you get that?
- Be sure to write this down
- This is important.
- This is not so important.
- Are you keeping up?

During the Session

- *Don't rely* on a tape recorder; good note taking is crucial.
- Make sure you're *sitting* in a place around the circle and can hear and see all of the participants.
- Be sure you can *communicate easily with the facilitator* without disrupting the discussion. Some note takers sit next to the facilitator; others prefer sitting across from the facilitator. Experiment and see what works best for your FGD team.
- Be sure the facilitator *introduces you* to the group. This will help ensure that the group feels comfortable speaking and understand your role.
- Be sure to write down each participant's name and record information provided during the introductions. Be sure you and the facilitator have a *seating chart* by the end of the introductions.
- Speak up if you missed something, but *don't become a second facilitator* and begin asking questions. Communicate with your facilitator if you think a topic needs more discussion.

Note-taking Tips

- *Number* your pages as you go.
- Write down the essential information, *not every single word*.
- *Summarize* with care; try not to reinterpret what people say. Use the words people use; catch good quotes whenever possible and mark them with quotation marks.
- Do not worry about perfect *handwriting*; you will write up a clean copy of your notes afterwards.
- Use *abbreviations* frequently.

- Use *quotation marks* under words to show repetition.

- Make use of indentations, spacing, and bullets to help *organize* your notes as you go.

- Try to indicate *who said what*; this can be made easier by using initials or a seat number from your seating chart.

- Try to record *nonverbal communication* (agreement, disagreement, confusion, surprise, etc.)

Using a Tape Recorder

- Good note taking is crucial, but a tape recorder can sometimes make the job easier. Unfortunately, many *tape recorders amplify sounds* such street traffic, rustling of papers, movements of chairs and feet, or eating or drinking to the point where you can not hear people speaking. It is not always worth the effort to record.

- Some tape recorders are *really only designed to play music* and possibly record voice at a time speaking directly into the microphone.

- Get *to know your machine*. Assess the quality of your tape recorder to see how much you can rely on it. Do a test run with batteries and with electricity. It is much stronger with electricity. Well before the FGD try recording family, friends, or co-workers in a mock FGD.

- Place the *microphone in various locations* (in front of the note taker often works best) and listen to how well different kinds of voices in different positions in the circle sound on the cassette.

- Remember that *batteries run down* very quickly when you record and the quality of the recording will deteriorate. (Don't make the mistake of playing music while waiting for people to arrive and having your batteries wear down!)

- Get *new batteries* and bring extras.

- In case there is electricity, bring *outlet adapters and an extension cord*.

- If you have a ***separate microphone*** instead of a built-in microphone, the tape recorder will be less intrusive. Pick one location for the microphone. Moving the microphone creates noisy static.

- Just before the FGD, set up the tape recorder *prior to the participants' arrival* and try recording to determine how much background noise there is in this location. See if you will be able to record all of the participants by speaking from several of the chairs.

- Have *enough tapes* for two hours of recording in case the session is long.

- Prepare *a new label* for each cassette marking date, place, and facilitator. Mark the cassettes "Side 1, "Side 2."

- Check tapes for *exact playing time* (if the tape says 30 minutes, it is usually 30 minutes total and NOT 30 minutes per side). As the time approaches, watch the cassette so you can catch

it when it is time to flip it over.

> Be sure you know *how to operate* the tape recorder quickly, since it will be necessary to turn the tape over during the middle of the session.

> Mark your notes when you *flip the cassette* so you can locate certain sections more quickly when you want to play back the cassette.

> Since some participants are concerned with confidentiality, it's best not to turn on the tape recorder until the facilitator *receives permission from the group*. (But don't forget to have the facilitator ask about the tape recorder before each person introduces herself/himself.)

> Leave the recorder running even after the facilitator "ends" the session to catch the final comments of people.

> DON'T LET THE TAPE RECORDER SUBSTITUTE FOR GOOD NOTE TAKING.

Annex B: Results Action Matrix Grouped by Follow-up Area: Services, Operations, Medical Quality, Administration, Payment, Contracting, Marketing

Table B-1. PHR Focus Group Results Summary: Family Health Care Pilot, Alexandria, January – February 2000

Topic/Issue	Patient	Provider	PHR Information Available	Short-term Action Suggested	Long-term Action Suggested
Service					
Want access to/more specialists in clinics	✓	✓		Add a few visiting specialists to units and centers; more training family docs and nurses	*Policy study*: feasibility of rotating specialists or multispecialty practices; reexamine economics of more centers versus units and multi-specialty models
Want emergency services at clinics	✓	✓		Ensure qualified emergency personnel assigned; training; phone	Include emergency in start-up of new sites
Want shorter waiting time (medical records system)	✓	✓	✓	Remove redundancy in records and consolidate required data collection for all programs; institute appt. system	Computerize medical records system at start-up with training at new sites
Want close location; short travel time and costs (border issue)	✓			Reassess options of where to refer	Master Plan check *Policy study*: organize intergovernorate cooperation for people along borders; information sharing; revenue issues
Operations					
Prefer day hours (causes crunch)	✓	✓		Look at incentives for afternoon/evening appointments	*Policy study*: Examine costs of operating hours/utilization; do away with two-tier price system; set up different operating hours in rural vs. urban areas based on demand (survey patient preferences)
Resolve shortage of pharmacists		✓		Pay overtime; recruit pharmacists	Promote pharmacist participation in Family Medicine (FM) programs
Resolve shortage of family docs/nurses	✓	✓	✓	Pay overtime; give priority in deployment of recent trainees to fill existing site shortages	Incentives for studying FM
Improve referral system	✓	✓	✓	Identify close referral sites; train referral sites in family file system and improve forms;	*Policy study*: Identify pilot hospitals and give them incentives to cooperate; explain benefits of FM to hospitals.

Topic/Issue	Patient	Provider	PHR Information Available	Short-term Action Suggested	Long-term Action Suggested
				Provide referral site incentives to cooperate; improve coordination with family planning (FP) and maternal child health (MCH) centers	Work out reasonable financing scheme for referred patients Inform patients clearly about referral procedures and costs
Want appointments	✓	✓		Institute appt system like Seuf in all sites	Install phones and take appts in new sites
Want telephone; transportation; Electric generators	✓	✓		Install telephone in all sites; provide petty cash for transportation; ensure both shifts have access to emergency vehicles; procure generators	Procure vehicles for sites in remote or periurban areas; review access to and number of emergency vehicles; check master plan, include phones and electric generators for vaccines and emergencies.
Want night security	✓	✓		Hire more guards/request police	Install sufficient lighting in site areas
Quality: Medical					
Want practical training in FP, reproductive health (RH), cardiology, other; nurses want more training in general		✓		Set up schedule of visiting consultants to current sites for hands on training with family docs/nurses	Provide practical, not only theoretical training in short-term family doc/nurse training until pool of FM specialists increases; include training on equipment
Want fewer restrictions on prescribing for chronic diseases		✓		Recommend special procedures for trial in pilot (EU consultants)	*Policy study*: pharmaceutical regulation, financing, dispensing policies, storage; essential drug list update; streamline HIO/MOHP systems
Revise medical records to include female, child, emergency special forms		✓	✓	Design forms adapting from pertinent vertical programs	Revise family file records across system
Want more health education materials	✓	✓		Strengthen cooperation with vertical programs; test and use Healthy Egyptians 2010 outreach in pilot sites; Identify priorities and assign	Standardize information to be distributed in new sites Set up health education/community outreach committee in each site

Topic/Issue	Patient	Provider	PHR Information Available	Short-term Action Suggested	Long-term Action Suggested
				tasks to TSO/TST and production budget	
Want training on equipment		✓	✓	QI assess equipment and training needs in current sites for docs/nurses; assign coordinator or business manager to follow up	Master Plan check
Quality: Administration					
Administration and supervision of site is full-time job		✓		Provide sufficient doctors so that directors do not have to see patients	Reassess job description/role of site director and role of business managers
Want Family Medicine "authority" in MOHP		✓		"Business Manager" (administrators) to be placed in directorate	Creation of FM Association Licensing and Accreditation; assign MOHP undersecretary for system-wide coordination
Need more storage space: Family files Drugs		✓		Drugs and files: look at current sites to see if more space can be arranged	Master Plan check
Payment					
Some willing to pay for location, short waiting time, to avoid referral; some unwilling/unable Noninsured, non-pilot pay high out of pocket for drugs; willing to pay for service, quality, drugs	✓	✓	✓	Start charging more at new sites at start-up (not after the fact)	Clarify exemption policy; fee scale, insurance Survey could dispel fears of political fallout or justify need for more government subsidy Conduct more focus groups on patient attitudes to payment, preferred methods of payment
Like security of insurance system; prefer monthly deductions; unsalaried	✓			Fund consider two forms of payment: per visit and salary deductions	Inform public of referrals covered by basic benefits package Negotiate prices for noncovered referrals on

Topic/Issue	Patient	Provider	PHR Information Available	Short-term Action Suggested	Long-term Action Suggested
prefer pay/visit					behalf of patients
MOHP facilities should charge less than private; also for lab and x-rays	✓	✓		Investigate fees at labs and private practices near sites; realign prices as necessary	Costing study will determine fees and/or needed government subsidy
Charge higher fee at start-up		✓	✓	Start charging at least 3 LE at opening of new clinics; determine priority services for exemption (pregnancy, FP, vaccination, etc.)	Insurance will be implemented
Charge for drugs		✓		To reduce potential reselling/hoarding/over-reliance on drugs	Investigate appropriate drug fees; establish photo ID system
Contracting					
Involve specialists	✓	✓		Give specialists incentives to cooperate with FM; visiting specialists	Multi-specialty practice; train specialists at referral sites in FM system
Avoid double rostering		✓		Set up database to audit records	Computer registration network; set-up control at registration
Develop monetary and non-monetary incentives		✓		Clarify criteria for supervisors; Specialists; overtime; non-roster patient visits	Establish mechanism for feedback/participation in pilot planning and replication; Government provide training for doctors/nurses
Strengthen cooperation with private and vertical programs		✓		Organize fair competition and cooperation with family health care system; business manager to promote cooperation with vertical programs	Conversion/integration/referral of vertical program services Provide private doctors/incentives; strengthen regulation of private practitioners; allow patient choice Publish orientation guidebook on FM system,

Topic/Issue	Patient	Provider	PHR Information Available	Short-term Action Suggested	Long-term Action Suggested
					operations, policies (FM association)
Promotion					
Patient marketing and public awareness; Family Medicine promotion to the professions		✓	✓	Promote family health care concept in pilot sites; community orientation on FM system and procedures in new sites;	MOHP mass promotion of FM specialty and benefits to patients Recruit patients for private/NGO collaborators Establish FM Association Coordinate with Social Fund Family Doctor project; Demonstrate government commitment post-donors
Redraw and test logo Promote quality/fund logo	✓	✓	✓	Redraw logo and test in focus groups; build on gold star recognition; begin community education of family health concept and coordinate with Social Fund	When family docs/nurses deployed to more pilot sites begin campaign to promote Family Medicine as quality care; testing in upper Egypt and delta governorates
Do not like word “Fund”	✓	✓		Add word “care” or “quality” “insurance” or “organization” to Family Health Fund name and test in focus groups	Promote logo after insurance law is passed or new policy instituted and more clinics accredited

Annex C: Result Topics by Theme Session

1. Patient Satisfaction (Seuf pilot patients and social workers)

- Family doctor/nurse and family file system
- Facility and staff
- Accessible location
- Specialists and referrals
- Appointment system
- Security at night
- Emergency services
- Pharmacy
- Health education visual aids/pamphlets
- Logo

2. Patient Willingness/Ability to Pay
   Insured males (Seuf pilot and HIO non-pilot patients; all pilot social workers)
   Uninsured females (Seuf pilot and MOHP non-pilot)

- Preferred method of payment
- Current health expenses
- Exemptions
- Satisfaction with current system

3. Professional Quality (Pilot physicians, nurses, social workers; all pilot facility directors)

- Practical training and manuals
- Accreditation
- Supplies and equipment
- Staffing patterns
- Security at night
- Emergency services
- Medical records and information system
- Specialists and referrals
- Pharmaceutical system
- Logo
- Health worker motivation
- Role of administrator

4. Provider Willingness to Contract with the Family Health Fund (pilot doctors and nurses; for-profit directors; NGO interview)

- Monetary and non-monetary incentives
- Performance-based measures
- Roster
- Public awareness campaigns
- Marketing
- Specialists and referrals

Annex D: Focus Group Topic Guides

First Session: Willingness to Contract with Family Health Fund

Physicians: Pilot MOHP Family Physicians, Pilot HIO Family Physicians (Seuf, Abu Qir, Gon, Mohsen, Khorshed) - Guiding Points

- Tell me about your current income, I mean your basic salary, approximately how much is it?
- What about your daily duty hours, how many hours do you work each day?
- What is the roster of families per health team (nurse and physician), and is this number suitable?
- How many patients do you see per day in your current work, I mean your usual workload per shift per day?
- In your opinion, is this workload suitable in relation to your current income or not, and why?
- In your opinion, what is the suitable income for a newly graduated physician working with the family physician system? Approximately how much per month?
- In your opinion, what is the suitable income for a physician with 10–15 years of experience? What is the approximate monthly salary?
- What is the appropriate salary for an experienced specialist?
- Do you prefer to be paid per visit or a monthly fixed salary amount as a way of payment? And why?
- Tell me about the system you have here for incentives: What are the criteria followed for incentive payments? Do you agree to such criteria or not, and why?
- What are your proposed criteria for incentives and proposed appropriate income?
- What do you think of the following criteria for incentive payments:
  - *Number of cases per day:* Do you agree with this criteria or not, and why?
  - *Patient satisfaction* with the service offered, which will be assessed periodically by means of a patient questionnaire. Do you agree or not, and why?
  - Achieving *coverage indicators* of MOHP vertical programs such as vaccinations and family planning. Do you agree or not, and why?

- *Drug prescription rate* and setting fine penalties or salary deductions for excessive drug prescription. Do you agree or not, and why?
- *Referral rates* to specialist and setting salary deductions for excessive referrals that could have been handled by the family physician.
- Sustained credibility of the place in terms of cleanliness, staff regular attendance, and duty hour's punctuality. Do you agree or not, and why?

- Are you currently working in private clinics after duty hours at the family health unit, or not, and why?

Second Session: Willingness to Contract with Family Health Fund

Nurses: Pilot MOHP Nurses, Pilot HIO Nurses (Seuf, Abu Qir, Goan, Mohsen, Khorshed) - Guiding Points

- Tell me about your current income, I mean your basic salary, approximately how much is it?
- What about your daily duty hours? How many hours do you work each day?
- What is the roster of families per health team (nurse and physician), and is this number suitable?
- How many patients do you see per day in your current work, I mean your usual workload per shift per day?
- In your opinion, is this workload suitable in relation to your current income or not, and why?
- In your opinion, what is the suitable income for a nurse newly graduated working with the family physician system? Approximately how much per month?
- In your opinion, what is the suitable income for a nurse with five years of experience working with the family physician system? What is the approximate monthly salary?
- Do you prefer to be paid per visit or a monthly fixed salary amount as a way of payment? And why?
- Tell me about the system you have here for incentives: What are the criteria followed for incentive payments. Do you agree to such criteria or not, and why?
- What are your proposed criteria for incentives and proposed appropriate income?
- What do you think of the following criteria for incentive payments:
  - Number of cases per day: Do you agree with this criteria or not, and why?
  - Patient satisfaction with the service offered, which will be assessed periodically by means of a patient questionnaire. Do you agree or not, and why?

- Achieving coverage indicators of MOHP vertical programs such as vaccinations and family planning. Do you agree or not, and why?
- Drug prescription rate and setting fine penalties or salary deductions for excessive drug prescription. Do you agree or not, and why?
- Referral rates to specialist and setting salary deductions for excessive referrals that could have been handled by the family physician.
- Sustained credibility of the place in terms of cleanliness, staff regular attendance, and duty hour's punctuality. Do you agree or not, and why?

- What do you think is the best way to charge treatment fees from insured and uninsured patients?
- Are you currently working in private clinics after duty hours at the family health unit, or not, and why?

Third Session: Pilot Monitoring – Professional Quality

Pharmacists: Pilot MOHP Pharmacists, Pilot HIO Pharmacists (Seuf, Abu Qir, Goan, Mohsen, Khorshed) - Guiding Points

- For how long have you been graduated?
- For how long have you been working in the family physician system?
- Have you received any training sessions on the family physician system, before or after joining the family physician system?
- Where did you receive this training and by whom?
- What are the main subjects of the training you have received?
- Do you feel that you have benefited from this training, or not?
- Have you ever worked before in the family physician system, or not?
- Where did you work before?
- Do you currently feel satisfied with your work as a family physician, or not, and why?
- What were your expectations regarding Family Medicine?
- What is your concept of the family physician in terms of his relationship with the patient?
- In your opinion, what are the responsibilities of pharmacist in the Family Health System?
- What are your suggestions to improve the work and services in the unit pharmacy?
- Is the unit drug quota enough for daily transactions?

- Are all essential drugs that are included in the primary health care list available?
- What are the uses of the current records?
- How are these records important to the family physician system?
- How do you assess the work of the rest of the health team?
- What do you think of the logo proposed for the Family Health Fund?
- What does this logo tell you?
- Do you think this logo will play any role in encouraging people to enroll in Family Health System?
- Do you wish to propose any additions of modifications to this logo?
- Do you have any idea about the objectives of 'Accreditation' of the unit? What do you understand about it?
- Are you familiar with the standards utilized in the accreditation of a unit?
- Do you think these standards are sufficient and satisfactory?
- Do you think the indicators for these standards can be measured?
- Do you think the accreditation system will affect the following:
  - Work system
  - Patient satisfaction
  - Provider satisfaction
  - Improvement of the service delivery
- Do you think that the accreditation requirements are consistent with the rules and regulations set for the MOHP and HIO establishments? Are there any contradictions?
- In your opinion, are the standards developed for the unit accreditation practical in terms of the following:
  - Patient rights
  - Overall patient care
  - Auxiliary services
  - Establishment administration
  - Human force
  - Information administration
  - Service quality assurance
  - Infection control

Fourth Session: Willingness to Contract with Family Health Fund

Private Physicians - Guiding Points

- Would you like to contract with the Family Health Fund at this pilot stage, or not, and why?
- Would you like to receive training in the family physician system, or not, and why?
- In your opinion, what are the advantages of joining the family physician system? Is it related to the income, or a better position, and why?
- As a way of payment, do you prefer to be paid per visit, or a fixed monthly salary, and why?
- What do you think is the suitable salary for a newly graduated family physician? Approximately how much monthly?
- In your opinion, what is the suitable monthly salary for a family physician with five years experience?
- In your opinion, what is the suitable monthly salary for a specialized physician with experience?
- What are your proposed criteria for incentive payments?
- What do you think of the following criteria for incentive payments:
  - Number of cases per day: Do you agree with this criteria or not, and why?
  - Patient satisfaction with the service offered, which will be assessed periodically by means of a patient questionnaire. Do you agree or not, and why?
  - Achieving coverage indicators of MOHP vertical programs such as vaccinations and family planning. Do you agree or not, and why?
  - Drug prescription rate and setting fine penalties or salary deductions for excessive drug prescription. Do you agree or not, and why?
  - Referral rates to specialist and setting salary deductions for excessive referrals that could have been handled by the family physician.
  - Sustained credibility of the place in terms of cleanliness, staff regular attendance, and duty hours punctuality. Do you agree or not, and why?
- What is the reasonable roster of families you can handle as a family physician, and what do you think the appropriate number should be?
- What do you think of the way reports are sent to the center?
- If you were to contract with the Family Health Fund, would you agree to treat the poor patients at a minimum charge such as 1 LE per visit, or not, and why?

- If you agree with the above issue, what percentage of the 300 families for which you may be responsible would benefit from the minimum charge?
- How many nurses do you have?
- What educational levels of nurses do you have (Secondary Technical Nurse, Technical Institute, Diploma nurse, or University/High Institute of Nursing graduate)?
- How much is each level paid?
- What is the rate of nurses per physicians?
- What kind of male patient services do the nurses offer?
- What kind of female patient services do the nurses offer?
- Do nurses work side by side with the physicians in service delivery, or do they have separate work?
- Do nurses have administrative responsibilities besides patient care, and what are these?

Patient Willingness to Pay – Guiding Points

- What did you learn from patients concerning the facilities with the least charges, is it the units of the MOH, HIO, the private physician clinic, or the NGO and mosque polyclinics?
- Have you learnt from the patients about their opinion on their willingness to pay more if the services offered are of an outstanding quality?
- Have you learnt from the patients about their opinion on their willingness to pay more if they are satisfied with the service offered to them?
- Have you learnt from patients about their opinion on terms of payment whether they prefer to pay per visit of a fixed amount, or both ways?
- If fixed payment, do they prefer yearly, quarterly, or monthly? Have you learnt from patients about their opinion on their willingness to pay per individual for all the members of the family as a whole?
- In terms of payment for non-insured patients, do they prefer to pay out of their pocket per visit, through salary deductions, or by adding the cost to other bills such as water of electricity bills?
- What did you here about the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were to be slightly increased, would it impact on the service utilization?
- Whom do patients think should be exempted from payment? And what are the criteria for exemption?

- Which of the following are patients willing to pay for besides the regular services:
  - Specialist consultations
  - Lab analysis
  - Drugs
  - Follow-up visits for same case
  - Examinations beyond the scope of the unit

Fifth Session – Patient Satisfaction

Pilot Social Workers: Seuf, Abu Qir, Gon, Mohsen, Khorshed – Guiding Points

Service Accessibility

- What did patients tell you about closeness of the center to their home or work place? Is it close or far?
- How do they get to the center? Do they use any transportation, and, if they do, what transportation means do they take?

Waiting Area

- What did you learn from patients about the waiting area in terms of:
  - Availability of suitable and comfortable chairs
  - Enough waiting area and sitting arrangements
  - Proper ventilation

Restrooms

- What did patients tell you about restrooms? Are they clean and sufficient in number, or not?

Examination Couch, Sheets, and Tablecloths

- What are patients' comments on examination couch, sheets, and tablecloths? Are they always clean, or not?

Waiting Time Spent in the Center

- Do patients complain of long waiting time until they see the physician?
- What reasons do they give for this condition?

Signs Inside and Outside the Center

- What did patients comment on signs inside the center? Are they enough and do they guide them to where they need to go, or not?

- What about signs outside the center? Do they attract their attention, and are they informative in any way?

Duty Hours, Reservation of Appointments and Ticketing System

- Do patients regard duty hours at the center are enough, or not?
- What do they think of the current reservation system?
- Have patients complained of any difficulties in obtaining tickets?
- What have you heard from patients concerning the possibility for reservations by phone?
- According to your experience with patients, do they regard the price of the ticket suitable, or not?
- What have you heard from patients about the difficulty of getting admitted to the examination room?

Availability of Drugs

- What did patients tell you about availability of drugs prescribed by the center physician?
- In case they do not find the drug at the center, from where do they get it?

Continuity of the Service

- What is the importance of being attended always by the same health team?
- Are referrals to another facility easy, or not?
- Have you heard from patients about what happens when they do not show up for timely vaccinations?
- And about being late for pregnancy follow-up?
- Do they realize that every time they visit the center, their family file is used for follow up and up dating records?
- What did patients tell you about the use of other clinics or polyclinics besides the unit?

Human Relationships and Service Delivery

- Have patients admitted they are always met with a friendly welcome by all unit personnel, whether physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers? Whom do they acknowledge most in this regard?
- Who considers most carefully their complaints and demands?

Communication and Understanding

Communication with Treating Physicians:

- Did patients admit that the treating physician listens carefully to their symptoms of pain and aches, inquires about and discusses their feelings of malaise, and answer all their questions?

Communication with Pharmacists:

- What did patients tell you about the pharmacists at the center? Do they explain and writes the use and dose of medication prescribed for them, and did they say that they trust him?

Feeling of Security and Privacy with the Health Team:

- From your experience with patients, did they express any feelings of security and privacy with the family physician, or not, and why?

- Did they express the same feelings with the nurse, of not, and why?

- How about their attitudes toward the social worker: Did they feel secure with them and discuss any personal problems when they were with them, or not, and why?

Health Education:

- Have patients indicated to you anything concerning availability of health education means at the center?

- And whether the means provided are informative enough, using posters and/or publications?

Proposed Family Health Fund Logo:

- I am going to distribute a tentative logo for Family Health Fund, and I want you to tell me your opinions about it, what you understand from it, the impressions it conveys to you, and whether it is acceptable, or not, and why?

Thoroughness of Health Services:

- Did you hear from patients any thing about their medical examination? Did the physician check their pulse, body temperature, and blood pressure each time they visited him?

- Did you hear from them that the physicians examine the patients carefully and thoroughly, or not?

- Did they tell you anything concerning the comprehensiveness of the service offered to them, and whether the physician takes enough time to examine each patient for all clinical signs, or not?

Overall Satisfaction with Health Service Delivery:

- Have patients indicated to you their overall satisfaction with this system, or not?

- In your opinion, what is the most common complaint among the patients?
- In your opinion, what is the aspect of service delivery in general, and patient satisfaction in particular, that the patients appreciate most?
  - Accessibility of the service
  - Sustainability of the service
  - Pleasant, good human relationships, and decent treatment by all personnel of the center
  - Easy two-way communication and understanding
  - Thoroughness of the service

Willingness to Pay for Family Health Care/Enrollment in Family Health Fund – Guiding Points

- Did you hear from patients their opinion on who offers them health services for the lowest prices, the MOH units, HIO units, the private physician, the NGO or the mosque polyclinics?
- Have you heard from the patients about their opinion on their willingness to pay more if the services offered are of an outstanding quality, or not, and why?
- Have you heard from the patients about their opinion on their willingness to pay more if they are satisfied with the service offered to them, or not, and why?
- Have you heard from patients about their opinion on terms of payment whether they prefer to pay per visit of a fixed amount, or both ways?
- If fixed payment, do they prefer yearly, quarterly, or monthly?
- Have you learnt from patients about their opinion on their willingness to pay per individual of for all the members of the family as a whole?
- In terms of payment for non-insured patients, do they prefer to pay out of their pocket per visit, through salary deductions, or by adding the cost to other bills such as water of electricity bills?
- What did you here about the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were slightly increased, would it impact on the service utilization?
- Whom do patients think should be exempted from payment? And what are the criteria for exemption?
- Which of the following are patients willing to pay for besides the regular services:

- Specialist consultations
- Lab analysis
- Drugs
- Follow-up visits for same case
- Examinations beyond the scope of the unit

Sixth Session – Patient Satisfaction

Pilot Patients: Insured Males (Seuf) – Guiding Points

Service Accessibility

- How do you usually come to the center? Do you use any transportation, and if you do what transportation means do you take?

Waiting Area

- What is your opinion about the waiting area in terms of:
  - Availability of suitable and comfortable chairs
  - Enough waiting area and sitting arrangements
  - Proper ventilation

Restrooms

- What about restrooms? Are they clean and sufficient in number, or not?

Examination Couch, Sheets and Tablecloths

- Do you have any comments on examination couch, sheets, and tablecloths? Are they always clean, or not?

Waiting Time Spent in the Center

- Do you wait a long time until you see the physician?
- Do you find any difficulty of getting admitted to the examination room?

Signs Inside and Outside the Center

- Are the signs inside the center enough and do they guide you to where you need to go, or not?
- What about signs outside the center, are they enough, and are they informative in any way?

Duty Hours, Reservation of Appointments and Ticketing System

- Are the duty hours at the center enough, or not?

- What do they think of the current reservation system?
- Do you face any difficulties in obtaining tickets?
- Do you like the possibility of reservations by phone?
- Is the price of the ticket suitable, or not?

Availability of Drugs

- Are the drugs prescribed by the family physician available at the pharmacy in the center?
- In case you do not find the drug at the center, from where do you buy it?

Continuity of the Service

- What is the importance of being attended always by the same doctor and nurse?
- Are referrals to another facility easy, or not?
- What happens when you do not show up for timely vaccinations?
- And what about being late for pregnancy follow-up: Do they usually remind the defaulters?
- Every time you visit the center or the unit, does the staff use your family file for follow-up and updating records?
- Do you use any other clinics or polyclinics besides the unit? Why?

Human Relationships and Service Delivery

- Do you feel that you are always met with friendly welcome by all unit personnel, whether physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers? Whom do you acknowledge most in this regard?
- Who considers most carefully your complaints and demands (physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers)?

Communication and Understanding

Communication with Treating Physicians:

- Does the physician listen carefully to your symptoms of pain and aches, inquire about and discuss your feelings of malaise, and answer all your questions?

Communication with Pharmacists:

- What about the pharmacists at the center? Do they explain and writes the use and dose of medication prescribed for you, and when you go to a private pharmacy without a written prescription, do they usually sell it to you?

Feeling of Security and Privacy with the Health Team:

- Do you feel the security and privacy with the family physician, or not, and why?
- Do you feel the same with the nurse, of not, and why?
- What about the social worker? Do you feel secure with them and discuss any personal problems, or not, and why?

Health Education:

- Do you find any health education materials (posters and/or publications)available at the center?
- Are they informative enough?

Proposed Family Health Fund Logo:

- Have you heard about the gold star program? Do you know what it stands for?
- I want you to tell me your opinion about this logo (Family Health Fund logo): What you understand from it, the impressions it conveys to you, and whether it is acceptable, or not, and why?

Thoroughness of Health Services:

- Does the physician check your pulse, body temperature, and blood pressure each time you visit him?
- Does he examine you carefully and thoroughly, or not? Does the physician take enough time to examine each patient or not?
- Do you feel the comprehensiveness of the service offered ?
- Before the family health center, where did you go for the family planning and for vaccinations?

Overall Satisfaction with Health Service Delivery

- After experiencing the family doctor system, are you satisfied with this system, or not?
- What is the aspect of service delivery that you most appreciate:
  - Sustainability of the service
  - Pleasant, good human relationships, and decent treatment by all personnel of the center
  - Easy two-way communication and understanding
  - Thoroughness of the service
  - Others (specify)

Willingness to Pay for Family Health Care/Enrollment in Family Health Fund – Guiding Points

Current and Previous Payment Method

- How much do you spend monthly per person on the drugs/doctor visits, etc. (average money spent per person on health)?
- From your previous experience, who offers health services for the lowest prices: MOH units, HIO units, the private physician, the NGO or the mosque polyclinics?
- How much do you pay monthly for drugs?

Proposed Methods of Paying

- Are you willing to pay more if the services offered are of an outstanding quality, or not, and why?
- Are you willing to pay more if you are satisfied with the service offered now or not, and why?
- Do you prefer to pay per visit or pay a fixed amount, or both ways?
- If fixed payment, do you prefer yearly, quarterly, or monthly?
- Would you like to pay per individual or for all the members of the family as a whole?
- In terms of payment for non-insured patients, do you prefer to pay out of your pocket per visit, or through salary deductions, or by adding the cost to other bills such as water of electricity bills?
- What is the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were slightly increased, would it impact on the service utilization?
- Whom do you think should be exempted from payment? And what are the criteria for exemption?
- Which of the following are you willing to pay for besides the regular services:
  - Specialist consultations
  - Lab analysis
  - Drugs
  - Follow-up visits for same case
  - Examinations beyond the scope of the unit

Seventh Session – Patient Satisfaction

Pilot Patients: Non-insured Females (Seuf) – Guiding Points

Service Accessibility

- How do you usually come to the center? Do you use any transportation, and if you do what transportation means do you take?

Waiting Area

- What is your opinion about the waiting area in terms of :
  - Availability of suitable and comfortable chairs
  - Enough waiting area and sitting arrangements
  - Proper ventilation

Restrooms

- What about restrooms? Are they clean and sufficient in number, or not?

Examination Couch, Sheets and Tablecloths

- Do you have any comments on examination couch, sheets, and tablecloths? Are they always clean, or not?

Waiting Time Spent in the Center

- Do you wait a long time until you see the physician?
- Do you find any difficulty of getting admitted to the examination room?

Signs Inside and Outside the Center

- Are the signs inside the center enough and do they guide you to where you need to go, or not?
- What about signs outside the center, are they enough, and are they informative in any way?

Duty Hours, Reservation of Appointments and Ticketing System

- Are the duty hours at the center enough, or not?
- What do you think of the current reservation system?
- Do you face any difficulties in obtaining tickets?
- Do you like the possibility of reservations by phone?
- Is the price of the ticket suitable, or not?

Availability of Drugs

- Are the drugs prescribed by the family physician available at the pharmacy in the center?
- In case you do not find the drug at the center, from where do you buy it?

Continuity of the Service

- What is the importance of being attended always by the same doctor and nurse?
- Are referrals to another facility easy, or not?
- What happens when you do not show up for timely vaccinations?
- And what about being late for pregnancy follow-up: Do they usually remind the defaulters?
- Every time you visit the center or the unit, does the staff use your family file for follow-up and updating records?
- Do you use any other clinics or polyclinics besides the unit? Why?

Human Relationships and Service Delivery

- Do you feel that you are always met with friendly welcome by all unit personnel, whether physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers? Whom do you acknowledge most in this regard?
- Who considers most carefully your complaints and demands (physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers)?

Communication and Understanding

Communication with Treating Physicians:

- Does the physician listen carefully to your symptoms of pain and aches, inquire about and discuss your feelings of malaise, and answer all your questions?

Communication with Pharmacists:

- What about the pharmacists at the center: Do they explain and write the use and dose of medication prescribed for you, and when you go to a private pharmacy without a written prescription, do they usually sell it to you?

Feeling of Security and Privacy with the Health Team:

- Do you feel the security and privacy with the family physician, or not, and why?
- Do you feel the same with the nurse, of not, and why?
- What about the social worker? Do you feel secure with them and discuss any personal problems, or not, and why?

Health Education:

- Do you find any health education materials (posters and/or publications) available at the center?
- Are they informative enough?

Proposed Family Health Fund Logo:

- Have you heard about the gold star program? Do you know what it stands for?
- I want you to tell me your opinion about this logo (FHF logo): What you understand from it, the impressions it conveys to you, and whether it is acceptable, or not, and why?

Thoroughness of Health Services:

- Does the physician check your pulse, body temperature, and blood pressure each time you visit him?
- Does he examine you carefully and thoroughly, or not? Does the physician take enough time to examine each patient or not?
- Do you feel the comprehensiveness of the service offered?
- Before the family health center, where did you use to go for the family planning and for vaccinations?

Overall Satisfaction with Health Service Delivery:

- After experiencing the family doctor system, are you satisfied with this system, or not?
- What is the aspect of service delivery that you appreciate most?:
  - Sustainability of the service
  - Pleasant, good human relationships, and decent treatment by all personnel of the center
  - Easy two-way communication and understanding
  - Thoroughness of the service
  - Others (specify)

Willingness to Pay for Family Health Care/Enrollment in Family Health Fund - Guiding Points

Current and previous payment method

- How much do you spend monthly per person on the drugs/doctors visits etc. (average money spent per person on health)

- From your previous experience, who offers health services for the lowest prices: MOH units, HIO units, the private physician, the NGO or the mosque polyclinics?
- How much do you pay monthly for drugs?

Proposed Methods of Paying

- Are you willing to pay more if the services offered are of an outstanding quality, or not, and why?
- Are you willing to pay more if you are satisfied with the service offered now or not, and why?
- Do you prefer to pay per visit or pay a fixed amount, or both ways?
- If fixed payment, do you prefer yearly, quarterly, or monthly?
- Would you like to pay per individual or for all the members of the family as a whole?
- In terms of payment for non-insured patients, do you prefer to pay out of your pocket per visit, or through salary deductions, or by adding the cost to other bills such as water of electricity bills?
- What is the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were slightly increased, would it impact on the service utilization?
- Whom do you think should be exempted from payment? And what are the criteria for exemption?
- Which of the following are you willing to pay for besides the regular services:
  - Specialist consultations
  - Lab analysis
  - Drugs
  - Follow-up visits for same case
  - Examinations beyond the scope of the unit

Eighth Session – Patient Satisfaction

Non-pilot Patients: Males – Guiding Points

Service Accessibility

- How do you usually come to the center? Do you use any transportation, and, if you do, what transportation means do you take?

Waiting Area

- What is your opinion about the waiting area in terms of:
  - Availability of suitable and comfortable chairs
  - Enough waiting area and sitting arrangements
  - Proper ventilation

Restrooms

- What about restrooms? Are they clean and sufficient in number, or not?

Examination Couch, Sheets, and Tablecloths

- Do you have any comments on examination couch, sheets, and tablecloths? Are they always clean, or not?

Waiting Time Spent in the Center

- Do you wait a long time until you see the physician?
- Do you find any difficulty of getting admitted to the examination room?

Signs Inside and Outside the Center

- Are the signs inside the center enough and do they guide you to where you need to go, or not?
- What about signs outside the center, are they enough, and are they informative in any way?

Duty Hours, Reservation of Appointments and Ticketing System

- Are the duty hours at the center enough, or not?
- What do they think of the current reservation system?
- Do you face any difficulties in obtaining tickets?
- Do you like the possibility of reservations by phone?
- Is the price of the ticket suitable, or not?

Availability of Drugs

- Are the drugs prescribed by the doctor available at the pharmacy in the center?
- In case you do not find the drug at the center, from where do you buy it?

Continuity of the Service

- What is importance of being attended always by the same doctor and nurse?

- Are referrals to another facility easy, or not?
- What happens when you do not show up for timely vaccinations?
- And what about being late for pregnancy follow-up? Do they usually remind the defaulters?
- Every time you visit the center or the unit, does the staff use your family file for follow-up and updating records?
- Do you use any other clinics or polyclinics besides the unit? Why?

Human Relationships and Service Delivery

- Do you feel that you are always met with friendly welcome by all unit personnel, whether physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers? Whom do you acknowledge most in this regard?
- Who considers most carefully your complaints and demands (physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers)?

Communication and Understanding

Communication with Treating Physician:

- Does the physician listen carefully to your symptoms of pain and aches, inquire about and discuss your feelings of malaise, and answer all your questions?

Communication with Pharmacists:

- What about the pharmacists at the center? Do they explain and write the use and dose of medication prescribed for you, and when you go to a private pharmacy without a written prescription, do they usually sell it to you?

Feeling of Security and Privacy with the Health Team:

- Do you feel the security and privacy with the doctor, or not, and why?
- Do you feel the same with the nurse, of not, and why?
- What about the social workers? Do you feel secure with them and discuss any personal problems, or not, and why?

Health Education:

- Do you find any health education materials (posters and/or publications) available at the center?
- Are they informative enough?

Proposed Family Health Fund Logo:

- Have you heard about the gold star program? Do you know what it stands for?

- I want you to tell me your opinion about this logo (FHF logo): What you understand from it, the impressions it conveys to you, and whether it is acceptable, or not, and why?

Thoroughness of Health Services:

- Does the physician check your pulse, body temperature, and blood pressure each time you visit him?
- Does he examine you carefully and thoroughly, or not? Does the physician take enough time to examine each patient or not?
- Do you feel the comprehensiveness of the service offered?
- Before the family health center, where did you use to go for the family planning and for vaccinations?

Overall Satisfaction with Health Service Delivery:

- Are you satisfied with this system, or not?
- What is the aspect of service delivery that you appreciate most?:
  - Sustainability of the service
  - Pleasant, good human relationships, and decent treatment by all personnel of the center
  - Easy two-way communication and understanding
  - Thoroughness of the service
  - Others (specify)

Willingness to Pay for Family Health Care/Enrollment in Family Health Fund - Guiding Points

Current and previous payment method

- How much do you spend monthly per person on the drugs/doctors visits, etc. (average money spent per person on health)?
- From your previous experience, Who offers health services for the lowest prices, MOH units, HIO units, the private physician, the NGO or the mosque polyclinics?
- How much do you pay monthly for drugs?

Proposed Methods of Paying

- Are you willing to pay more if the services offered are of an outstanding quality, or not, and why?
- Are you willing to pay more if you are satisfied with the service offered now or not, and

why?

- Do you prefer to pay per visit or pay a fixed amount, or both ways?
- If fixed payment, do you prefer yearly, quarterly, or monthly?
- Would you like to pay per individual or for all the members of the family as a whole?
- In terms of payment for non-insured patients, do you prefer to pay out of your pocket per visit, or through salary deductions, or by adding the cost to other bills such as water of electricity bills?
- What is the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were slightly increased, would it impact on the service utilization?
- Whom do you think should be exempted from payment? And what are the criteria for exemption?
- Which of the following are you willing to pay for besides the regular services:
  - Specialist consultations
  - Lab analysis
  - Drugs
  - Follow-up visits for same case
  - Examinations beyond the scope of the unit

Ninth Session – Patient Satisfaction

Non-Pilot Patients: Females – Guiding Points

Service Accessibility

- How do you usually come to the center? Do you use any transportation, and if you do what transportation means do you take?

Waiting Area

- What is your opinion about the waiting area in terms of:
  - Availability of suitable and comfortable chairs
  - Enough waiting area and sitting arrangements
  - Proper ventilation

Restrooms

- What about restrooms? Are they clean and sufficient in number, or not?

Examination Couch, Sheets, and Tablecloths

- Do you have any comments on examination couch, sheets, and tablecloths? Are they always clean, or not?

Waiting Time Spent in the Center

- Do you wait a long time until you see the physician?
- Do you find any difficulty of getting admitted to the examination room?

Signs Inside and Outside the Center

- Are the signs inside the center enough and do they guide you to where you need to go, or not?
- What about signs outside the center, are they enough, and are they informative in any way?

Duty Hours, Reservation of Appointments and Ticketing System

- Are the duty hours at the center enough, or not?
- What do you think of the current reservation system?
- Do you face any difficulties in obtaining tickets?
- Do you like the possibility of reservations by phone?
- Is the price of the ticket suitable, or not?

Availability of Drugs

- Are the drugs prescribed by the doctor available at the pharmacy in the center?
- In case you do not find the drug at the center, from where do you buy it?

Continuity of the Service

- What is the importance of being attended always by the same doctor and nurse?
- Are referrals to another facility easy, or not?
- What happens when you do not show up for timely vaccinations?
- And what about being late for pregnancy follow-up? Do they usually remind the defaulters?
- Every time you visit the center or unit, does the staff use your family file for follow-up and updating records?
- Do you use any other clinics or polyclinics besides the unit? Why?

Human Relationships and Service Delivery

- Do you feel that you are always met with friendly welcome by all unit personnel, whether physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers? Whom do you acknowledge most in this regard?

- Who considers most carefully your complaints and demands (physicians, nurses, pharmacists, social workers, lab technicians, inventory clerks, or security officers)?

Communication and Understanding

Communication with Treating Physicians:

- Does the physician listen carefully to your symptoms of pain and aches, inquire about and discuss your feelings of malaise, and answer all your questions?

Communication with Pharmacists:

- What about the pharmacists at the center: Do they explain and writes the use and dose of medication prescribed for you, and when you go to a private pharmacy without a written prescription, do they usually sell it to you?

Feeling of Security and Privacy with the Health Team:

- Do you feel the security and privacy with the doctor, or not, and why?

- Do you feel the same with the nurse, of not, and why?

- What about the social workers? Do you feel secure with them and discuss any personal problems, or not, and why?

Health Education:

- Do you find any health education materials (posters and/or publications) available at the center?

- Are they informative enough?

Proposed Family Health Fund Logo:

- Have you heard about the gold star program? Do you know what it stands for?

- I want you to tell me your opinion about this logo (FHF logo): What you understand from it, the impressions it conveys to you, and whether it is acceptable, or not, and why?

Thoroughness of Health Services:

- Does the physician check your pulse, body temperature, and blood pressure each time you visit him?

- Does he examine you carefully and thoroughly, or not? Does the physician take enough time to examine each patient or not?

- Do you feel the comprehensiveness of the service offered?
- Before the family health center, where did you use to go for the family planning and for vaccinations?

Overall Satisfaction with Health Service Delivery:

- Are you satisfied with this system, or not?
- What is the aspect of service delivery that you appreciate most?:
  - Sustainability of the service
  - Pleasant, good human relationships, and decent treatment by all personnel of the center
  - Easy two-way communication and understanding
  - Thoroughness of the service
  - Others (specify)

Willingness to Pay for Family Health Care/Enrollment in Family Health Fund - Guiding Points

Current and previous payment method

- How much do you spend monthly per person on the drugs/doctors visits, etc. (average money spent per person on health related)
- From your previous experience, who offers health services for the lowest prices: MOH units, HIO units, the private physician, the NGO or the mosque polyclinics?
- How much do you pay monthly for drugs?

Proposed Methods of Paying

- Are you willing to pay more if the services offered are of an outstanding quality, or not, and why?
- Are you willing to pay more if you are satisfied with the service offered now or not, and why?
- Do you prefer to pay per visit or pay a fixed amount, or both ways?
- If fixed payment, do you prefer yearly, quarterly, or monthly?
- Would you like to pay per individual or for all the members of the family as a whole?
- In terms of payment for non-insured patients, do you prefer to pay out of your pocket per visit, or through salary deductions, or by adding the cost to other bills such as water of electricity bills?

- What is the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were slightly increased, would it impact on the service utilization?
- Whom do you think should be exempted from payment? And what are the criteria for exemption?
- Which of the following are you willing to pay for besides the regular services:
  - Specialist consultations
  - Lab analysis
  - Drugs
  - Follow-up visits for same case
  - Examinations beyond the scope of the unit

Tenth Session – Willingness to Contract with Family Health Fund

NGOs: Directors/Physicians – Guiding Points

- Would you like to contract with the Family Health Fund at this pilot stage, or not, and why?
- Would you like to receive training in the family physician system, or not, and why?
- In your opinion, what are the advantages of joining the family physician system, is it related to the income, or a better position, and why?
- As a way of payment, do you prefer to be paid per visit, or a fixed monthly salary, and why?
- What do you think is the suitable monthly salary for a newly graduated family physician?
- In your opinion, what is the suitable monthly salary for a family physician with five years experience?
- In your opinion, what is the suitable monthly salary for a specialized physician with experience?
- What are your proposed criteria for incentive payments?
- What do you think of the following criteria for incentive payments:
  - Number of cases per day: Do you agree with this criteria or not, and why?
  - Patient satisfaction with the service offered, which will be assessed periodically by means of a patient questionnaire. Do you agree or not, and why?

- Achieving coverage indicators of MOHP vertical programs such as vaccinations and family planning. Do you agree or not, and why?
- Drug prescription rate and setting fine penalties or salary deductions for excessive drug prescription. Do you agree or not, and why?
- Referral rates to specialist and setting salary deductions for excessive referrals that could have been handled by the family physician.
- Sustained credibility of the place in terms of cleanliness, staff regular attendance, and duty hours punctuality. Do you agree or not, and why?

- What is the reasonable roster of families you can handle as a family physician, and what do you think the appropriate number should be?
- What do you think of the way reports are sent to the center?
- If you were to contract with the Family Health Fund, would you agree to treat the poor patients at a minimum charge such as 1 LE per visit, or not, and why?
- If you agree with the above issue, what percentage of the 300 families for which you may be responsible, would benefit from the minimum charge?
- How many nurses do you have?
- What educational levels of nurses do you have (Secondary Technical Nurse, Technical Institute, Diploma nurse, or University/High Institute of Nursing graduate)?
- How much is each level paid?
- What is the rate of nurses per physicians?
- What kind of male patient services do the nurses offer?
- What kind of female patient services do the nurses offer?
- Do nurses work side by side with the physicians in service delivery, or do they have separate work?
- Do nurses have administrative responsibilities besides patient care, and what are these?

Patients Willingness to Pay for Family Health Care - Guiding Points

- What did you learn from patients concerning the facilities with the least charges, is it the units of the MOH, HIO, the private physician clinic, or the NGO and mosque polyclinics?
- Have you learnt from the patients about their willingness to pay more if the services offered are of an outstanding quality?
- Have you learnt from the patients about their willingness to pay more if they are satisfied with the service offered to them?

- Have you learnt from patients about their opinion on terms of payment: whether they prefer to pay per visit of a fixed amount, or both ways?
- If fixed payment, do they prefer yearly, quarterly, or monthly? Have you learnt from patients about their willingness to pay per individual for all the members of the family as a whole?
- In terms of payment for non-insured patients, do they prefer to pay out of their pocket per visit, through salary deductions, or by adding the cost to other bills such as water of electricity bills?
- What did you here about the suitable amount a person can pay per year in order to benefit from the family physician system?
- If this amount were to be slightly increased, would it impact on the service utilization?
- Whom do patients think should be exempted from payment? And what are the criteria for exemption?
- Which of the following are patients willing to pay for besides the regular services:
  - Specialist consultations
  - Lab analysis
  - Drugs
  - Follow up visits for same case
  - Examinations beyond the scope of the unit

Eleventh Session – Pilot Monitoring: Professional Quality

Directors of the Five Units: Seuf, Abu Qir, Gon, Mohsen, Khorshed – Guiding Points

Questions for Directors as Unit Administrators:

- For how long have you worked as director of this unit?
- What is your concept of the administration team?
- What is your assessment of the unit equipment and available capabilities?
- What is your assessment of the reporting system for the family physician system?
- Are you satisfied with the administration of the unit?
- In your opinion, what is the appropriate percentage of your time that should be spent on administration, and what percentage on practicing as a family physician?
- What are your suggestions to improve the work and services in the unit pharmacy?

- Is the unit drug quota enough for daily transactions?
- Are all essential drugs included in the primary health care list available?
- What is your knowledge or information on the financial status of the unit?
- Have you received any training in financial management and budgeting?

Questions Targeted to their Work as Family Physicians:

- For how long have you been graduated?
- Have you had any post-graduate studies, or not? If yes, in what branch?
- For how long have you been working as a family physician?
- Have you received any training sessions on the family physician system, before or after joining the family physician system?
- Where did you receive this training and by whom?
- What are the main subjects of the training you have received?
- Do you feel that you have benefited from this training, or not?
- Have you ever worked before in the family physician system, or not?
- Where did you work before?
- Do you currently feel satisfied with your work as a family physician, or not, and why?
- What were your expectations regarding Family Medicine?
- What is your concept of the family physician in terms of his relationship with the patient?
- In your opinion, what are the responsibilities of a family physician?
- What are the uses of the current records?
- How are these records important to the family physician?
- How do you assess the work of the rest of the health team?
- How do you process the referral cases?
- What do you think of the current referral system?
- Do you receive any referral feedback?
- How do you transport the referred cases to the hospital?

- What do you propose to improve the services available at the family health unit?
- What do you think of the logo proposed for the Family Health Fund?
- What does this logo tell you?
- Do you think this logo will play any role in encouraging people to enroll in Family Health Fund?
- Do you wish to propose any additions of modifications to this logo?
- Do you have any idea about the objectives of 'Accreditation' of the unit? What do you understand about it?
- Are you familiar with the standards utilized in the accreditation of a unit?
- Do you think these standards are sufficient and satisfactory?
- Do you think the indicators for these standards can be measured?
- Do you think the accreditation system will affect the following:
  - Work system
  - Patient satisfaction
  - Provider satisfaction
  - Improvement of the service delivery
- Do you think that the accreditation requirements are consistent with the rules and regulations set for the MOHP and HIO establishments? Are there any contradictions?
- In your opinion, are the standards developed for the unit accreditation practical in terms of the following:
  - Patient rights
  - Overall patient care
  - Auxiliary services
  - Establishment administration
  - Human force
  - Information administration
  - Service quality assurance
  - Infection control

Twelfth Session – Pilot Monitoring: Professional Quality

Family Physicians: Seuf

- For how long have you been graduated?
- Have you had any post-graduate studies, or not? If yes, in what branch?
- For how long have you been working as a family physician?
- Have you received any training sessions on the family physician system, before or after joining the family physician system?
- Where did you receive this training and by whom?
- What are the main subjects of the training you have received?
- Do you feel that you have benefited from this training, or not?
- Have you ever worked before in the family physician system, or not?
- Where did you work before?
- Do you currently feel satisfied with your work as a family physician, or not, and why?
- What were your expectations regarding Family Medicine?
- What is your concept of the family physician in terms of his relationship with the patient?
- In your opinion, what are the responsibilities of a family physician?
- What are the uses of the current records?
- How are these records important to the family physician?
- How do you assess the work of the rest of the health team?
- How do you process the referral cases?
- What do you think of the current referral system?
- Do you receive any referral feedback?
- How do you transport the referred cases to the hospital?
- What do you propose to improve the services available at the family health unit?
- What do you think of the logo proposed for the Family Health Fund?
- What does this logo tell you?

- Do you think this logo will play any role in encouraging people to enroll in Family Health Fund?
- Do you wish to propose any additions of modifications to this logo?
- Do you have any idea about the objectives of 'Accreditation' of the unit? What do you understand about it?
- Are you familiar with the standards utilized in the accreditation of a unit?
- Do you think these standards are sufficient and satisfactory?
- Do you think the indicators for these standards can be measured?
- Do you think the accreditation system will affect the following:
  - Work system
  - Patient satisfaction
  - Provider satisfaction
  - Improvement of the service delivery
- Do you think that the accreditation requirements are consistent with the rules and regulations set for the MOHP and HIO establishments? Are there any contradictions?
- In your opinion, are the standards developed for the unit accreditation practical in terms of the following:
  - Patient rights
  - Overall patient care
  - Auxiliary services
  - Establishment administration
  - Human force
  - Information administration
  - Service quality assurance
  - Infection control

Thirteenth Session – Pilot Monitoring: Professional Quality

Nurses and Social Workers: Seuf – Guiding Points

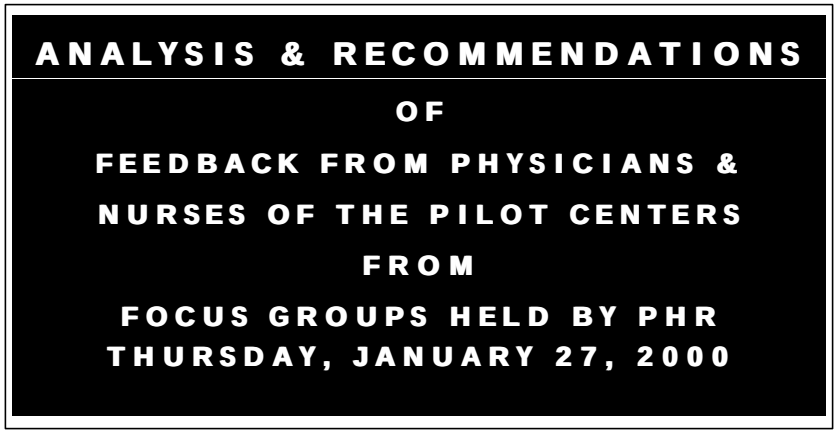
- For how long have you been graduated?
- For how long have you been working in the family physician system?
- Have you received any training sessions on the family physician system, before or after

joining the family physician system?

- Where did you receive this training and by whom?
- What are the main subjects of the training you have received?
- Do you feel that you have benefited from this training, or not?
- Have you ever worked before in the family physician system, or not?
- Where did you work before?
- Do you currently feel satisfied with your work as a family physician, or not, and why?
- What were your expectations regarding Family Medicine?
- What is your concept of the family physician in terms of his relationship with the patient?
- In your opinion, what are the responsibilities of a nurse/social worker in the Family Health System?
- What are the uses of the current records?
- How are these records important to the family physician system?
- How do you assess the work of the rest of the health team?
- How do you process the referral cases?
- What do you think of the current referral system?
- Do you receive any referral feedback?
- How do you transport the referred cases to the hospital?
- What do you propose to improve the services available at the family health unit?
- What do you think of the logo proposed for the Family Health Fund?
- What does this logo tell you?
- Do you think this logo will play any role in encouraging people to enroll in Family Health System?
- Do you wish to propose any additions of modifications to this logo?
- Do you have any idea about the objectives of ‘Accreditation’ of the unit? What do you understand about it?
- Are you familiar with the standards utilized in the accreditation of a unit?
- Do you think these standards are sufficient and satisfactory?

- Do you think the indicators for these standards can be measured?
- Do you think the accreditation system will affect the following:
  - Work system
  - Patient satisfaction
  - Provider satisfaction
  - Improvement of the service delivery
- Do you think that the accreditation requirements are consistent with the rules and regulations set for the MOHP and HIO establishments? Are there any contradictions?
- In your opinion, are the standards developed for the unit accreditation practical in terms of the following:
  - Patient rights
  - Overall patient care
  - Auxiliary services
  - Establishment administration
  - Human force
  - Information administration
  - Service quality assurance
  - Infection control

Annex E: SWOT Analysis on Primary Care Reform Based on Pilot Provider Feedback



RECOMMENDATIONS

HUMAN RESOURCE RECOMMENDATIONS:

1. Issue the previous period incentives of the pilot staff.
2. Review, agree, present and follow thoroughly the performance standards to the staff.
3. Dispense the incentives in a timely manner.
4. Tailor standards for dentists, other minority groups.
5. Acknowledge the personnel for their points of strengths.
6. Set a continuous learning program to staff to augment their performance and motivate them.

ADMINISTRATIVE RECOMMENDATIONS:

1. Organize the appointments, the visit time to doctors, the number of patients/dr./day and follow it strictly.
2. Make available expenses for center cleaning facilities, if centers are to be evaluated according to cleanliness.

SERVICE RECOMMENDATIONS:

1. Complete the range of services in the pilot centers.
2. Complete the range of medications required.

MARKETING REOMMENDATIONS:

1. Address the value for money paid by the patient.
2. Supply and update the center with health education materials.

TECHNICAL RECOMMENDATIONS:

Review the family file with the objective of reducing the amount of paper work.

1. Review the logic behind 2 L.E. family physicians ticket = 4L.E. specialist ticket. It could be added up to a total of 4 L.E. if transferred on the same day or… another option.

2. Keep up with the number of families assigned to each family physician and do not exceed it.

SWOT ANALYSIS

STRENGTHS	WEAKNESSES
T Reasonable number of families per Dr. **T** Health insurance clinic patient realized an improved service in the new system. **T** Staff is enthusiastic to get paid according to their performance evaluation. **T** Teamwork spirit and feeling all in one unit responsible for the overall success. **T** Staff is productivity oriented i.e. they understand how important the number and quality and degree of responsibility for the patients are. **T** Staff is aware of the value of patient satisfaction in the center. **T** Staff willingness to follow the clinical guidelines. **T** Staff devotion to their work.	**:** The low basic salary. **:** Number of patients is sometimes larger than the number of working hours. **:** Control on limiting the visit of patients to only one unit. **:** Feeling of detachment of dentists from the program and its objectives. **:** The price of some services is higher than in other sectors i.e. the free of charge MOHP Mobile clinics, Army clinics, mother and child centers. **:** Now complete range of services in some of the centers i.e. lab services. **:** Appointing patients and organizing their entrance needs attention and control. **:** Deficiency in some medications. **:** The patient suffers from paying 2 L.E. = 4 L.E. if the family doctor transfers him to a specialist inside the center. **:** The detailed, repeated, time consuming, long procedures of filling forms of the family file. **:** Unavailability of budget for cleanliness of the center in some cases. Staff sometimes pay out of their own pocket.
OPPORTUNITIES	**THREATS**
(Willingness of staff to learn and to get trained. **(** Willingness of staff to offer high-level health education efforts. **(** Satisfying the staff income levels can trigger their enthusiasm and devotion to the health reform program.	**;** A flow > 25 patient per day may affect the quality of service offered by the center. **;** The non-paid incentive decreased the income of staff. This can make them lose confidence in the program and affect their willingness to back it. **;** Putting any irrelevant performance evaluation standards can trigger staff reluctance in service delivery by the staff.

Annex F: Bibliography

Abd El Fattah, Hassan, Ibrahim Saleh, Emad Ezzat, Sameh El Saharty, Maha El Adawy, A.K. Nandakumar, Catherine Connor, Hassan Salah. 1997. The Health Insurance Organization of Egypt: an Analytical Review and Strategy for Reform. Technical Report No. 43. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Afifi, Nihal, Sameh El-Saharty, George Schieber et al. 1997. The Egypt Health Sector Reform Program. Cairo: Ministry of Health and Population of Egypt.

Berman,Peter, A.K. Nandakumar, Jean-Jacques Frere, Hassan Salah, Maha El-Adawy, Sameh El-Saharty, and Nabil Nassar. 1997. "A Reform Strategy for Primary Care in Egypt." Technical Report No. 9. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Bossert, Thomas, Nihal Hafez, Wessam El Beih. 1998. Preliminary Institutional Assessment of the Alexandria Health Reform Pilot. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Brinkerhoff, Derek and Susan Scribner. 1999. Strategic Approaches and Tools for Policy Reform Implementation: Exploring Applications to Egypt's Health Reform Program. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Cressman, Gordon and Mary St. John. 1999. Health Information Systems Planning. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Debus, Mary. 1988. Handbook for Excellence in Focus Group Research. Washington, DC: Porter-Novelli and Academy for Educational Development (AED/HEALTHCOM).

Edmond, Alan, Mary Paterson, Ahsan Sadiq, Linda Sadiq, Susan Scribner, Nena Terrell. 1999. Establishment of the Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Pilot Project for Family Health Care. Technical Report No. 42. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Edmond, Alan and Susan Scribner. 1999. Planning for Implementation of the Family Health Fund. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Forte, Michael A. 2000. Medical Records Assessment in the Pilot Project for Family Health Care. Technical Report No. 51. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Gaumer, Gary. 1998. Egypt Pilot Planning Payment Methods. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

_____. 2000. Development and Training of the Family Health Fund Performance Reporting System. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Kazandjian,Vahe. 1998. Implementation of an Indicator-based Performance System for Health Care Facilities in Egypt. Cairo: Partnerships for Health Reform, Abt Associates Inc.

Ministry of Health and Population, Arab Republic of Egypt. 1999. A New Egyptian Health Care Model for the 21st Century. Cairo: Partnerships for Health Reform, Abt Associates Inc.

Nandakumar, A.K., Mahmoud Abdel-Latif, Wessam el-Beih. 1999. Options for financing Health Services in Pilot Facilities in Alexandria. Technical Report No. 36. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Obermeyer, Carla Makhlouf. 1998. Preparatory Work for Qualitative Research Project on User Perspectives on Health Services in Alexandria. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Paterson, Mary. 1998. Assessment of Health Management Capacity in MOHP Outpatient Clinics in Montazah District, Alexandria. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Rafeh, Nadwa. 2000. Facility Accreditation Survey Instrument: Development and Testing. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Rasmussen, Bjarne Lading, Grete Budsted, Annette Poswiata, Karen Ellen Spannow, Andreas Eskesen, Per Milde. 1999. "Guidelines for District Health Planning" (Master Plan). Cairo, Egypt: National Health Planning Standards and Guidelines, MOHP.

Sadiq, Linda. 1999. Financing Policy Issues and Options: Second Work Planning Session for Implementation of the Family Health Fund. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

_____. 2000. Role of Accreditation and Contracting in the Family Health Care Pilot Project: Third Work Planning Session for Establishment of the Family Health Fund. Trip report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

_____. 2000. Performance Management in the Alexandria Governorate Family Health Fund. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Terrell, Nena. 1998. Communications and Marketing for Egypt Health Sector Reform. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

_____. 1998. Organizing Communications Work for Egypt Pilot Project and Health Reform Program. Trip Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.